

YALOM'S 60 Q-SORT OF CURATIVE FACTORS  
IN GROUP THERAPY APPLIED TO PARENT  
TRAINING GROUPS

DENISE ELIZABETH LAWLOR









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YALOM'S 60 ITEM Q-SORT OF CURATIVE FACTORS  
IN GROUP THERAPY APPLIED TO PARENT TRAINING GROUPS

By



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A Thesis submitted in partial fulfillment  
of the requirements for the degree of  
Master of Social Work

School of Social Work  
Memorial University of Newfoundland

March 15, 1982

St. John's

Newfoundland



## Abstract

This quantitative-descriptive study reports data regarding the nature of curative factors existing in parent training groups. The group therapy was administered in the form of Parent Training (PT) groups in seven sessions. The study sample was composed of 21 parents who all participated in the PT. Three PT groups were held consecutively between the months of May and November, 1981 at the Planned Parenthood Association office in St. John's, Newfoundland, Canada. Data were collected by means of a structured questionnaire administered individually to all group members. The major component of this instrument was the Q-sort Analysis of Curative Factors (Yalom, 1975), which was a forced choice rank ordering of 60 items, which pertained to 12 specific outcome or curative factors.

Analyses indicated: 1) that these parents were predominately middle aged females of middle-lower class socioeconomic status, 2) they had at least one child between the ages of 5-12 years and 3) each parent came to group therapy with specific problems related to parenting with the hope of finding help.

The Q-sort questionnaire provided evidence that specific curative factors were more helpful than others to parents who attended PT. The factors deemed as most

helpful were: 1) 'Instillation of hope', 2) 'Altruism', 3) 'Group cohesiveness', 4) 'Catharsis', 5) 'Universality', and 6) 'Guidance'. The factors deemed as less helpful were: 1) 'Interpersonal learning "output"', 2) 'Self-understanding', 3) 'Identification', 4) 'Family reenactment', 5) 'Existential factors' and 6) 'Interpersonal learning "input"'. .



### Acknowledgements

My deepest appreciation is extended to my thesis supervisor, Dr. Michael Hološko, who provided extensive research expertise, as well as continuous direction and support in supervising me throughout this endeavour. I wish to express my thanks to Professor Gary Gould for his clinical expertise and giving me the idea for this study.

Appreciation and special thanks are extended to Irvin D. Yalom who did considerable research in the field of group therapy. This list of curative factors which he compiled into a 60 item Q-sort questionnaire was the major instrument used in this study.

I wish to extend my gratitude to all the staff of Planned Parenthood Association of Newfoundland and Labrador at 21 Factory Lane, St. John's, Newfoundland. Special consideration should go out to Mrs. May Johnson, Mrs. Diane Siegel and Mrs. Carolyn Butler, who provided assistance and the opportunity for me to partake in this study. Special thanks are extended to my colleague, friend, and co-leader in the group sessions, Ms. Beverley Vincent, who provided support and direction throughout the groups. Finally, I would like to thank most of all the parents, who gave their time to partake in this study.

I would also like to extend special thanks to Kay White, who provided assistance in typing this study.

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VALOM'S 60 ITEM Q-SORT OF CURATIVE FACTORS  
IN GROUP THERAPY APPLIED TO PARENT TRAINING GROUPS

Denise E. Lawlor

The use of group therapy to increase self-understanding and improve the quality of interpersonal relationships is being rediscovered in various fields of psychology, medicine, education, social work and business. The study and usefulness of group therapy has had a long history in the field of social work. Foremost, the seminal work of Kurt Lewin (1947) stressed the importance of the group as a system of interrelated parts and persons. He suggested that only when individuals discovered facts about themselves, were their attitudes and subsequent behaviors changed (Lewin, Lippitt and White, 1939).

In the late 1940's, the practice of group therapy in the United States and Canada became more widespread in health care and hospital settings. Subsequently, it originated in response to a shortage of personnel trained to provide individual therapy (Corey and Corey, 1977). The dynamics of group therapy offered new possibilities in providing support, caring, confrontation and other qualities not found in individual therapy (Corey and Corey, 1977).

In most group therapies, group members are more apt to learn about themselves through their interactions with other members. Today, group therapy is usually focused around the specific problems of its members. No one group is identical to another as every group brings with it

unique individuals with unique problems.

Group members participate in group therapy for many reasons. Outside of clinical referrals for problems, individuals may participate in order to alleviate specific problems, such as depression, fear, anxiety, sexual problems, and/or alcoholism. The literature generally indicates that all groups have the broad and expressed purpose of increasing an individual's knowledge of themselves and others. Thus, groups represent a set of opportunities for group members to share and learn from each other (Corey and Corey, 1977; Yalom, 1975).

The major goal of any form of group therapy is to produce individual change through the group members. Most therapists agree that individual change in groups occurs because of specific forces operating within the group. These forces when related to the outcome of the group are generally termed "curative factors", and they include a wide range of variables such as instillation of hope, group cohesiveness, universality, catharsis, imparting of information, etc., (Yalom; 1975, p. 77).

Very little systematic research has examined the comparative value of curative factors in group therapy, yet most researchers tend to agree that specific curative factors are apparent in every group. For example, a group which focuses on Parent Effectiveness Training (PET) aims to facilitate group members in becoming better parents. In turn, specific curative factors operate in group therapy



in view of the outcome goals of PET. By measuring outcome in this way, researchers attempt to measure the effectiveness of group therapy. This study seeks to explore the nature of certain outcome or curative factors in this regard.

#### Statement of Problem

The purpose of this study is to determine whether certain curative factors are apparent in specialized group therapy for Parent Training. For example, some research has determined that the effectiveness of group therapy directly depends on the existence of specific curative factors (Corey and Corey, 1977; Lieberman, Yalom and Miles, 1972; Berzon, Pious and Parson, 1963; and Dickoff and Lakin, 1963).

The type of group therapy used and studied will be a modified form of PET as outlined by Gordon (1975). It will be herein referred to as Parent Training (PT). The objectives of the PT groups will be as follows: 1) parents share their concerns with other parents and learn they are not alone, 2) parents learn new skills and ways of coping with their children, and 3) parents become more effective parents for meeting their own personal needs.

The effectiveness of the PT groups will be assessed by exploring the curative factors which are apparent in the groups. Twelve categories of curative factors will be tested as outlined in Yalom's landmark study (1975). A Q-sort questionnaire will be administered to all group

members who are part of the PT group therapy.

Three PT groups were led by two co-therapists who used similar teaching/training methods. Each group met for 2-hour weekly sessions for seven consecutive weeks. There were no major differences in the PT groups in terms of group members, size, or content of the sessions.

Research has shown that the nature of group therapy is an important variable in considering which curative factors exist in various groups (Yalom, 1975; Bach, 1967). Consequently, this study will seek to determine whether the actual type of group therapy impacts on the nature of curative factors for these respective groups.

#### Rationale for Study

This study may assist therapists in learning more about the nature and importance of PT. For example, determining the clinical relevance of curative factors may assist therapists in evaluating PT group therapy.

By studying curative factors, one may be better able to compare which curative factors are related to treatment. For example, group therapy involves people interacting on two levels, emotional and intellectual, with a final goal of understanding the interrelationships of how people act. Thus, in every group experience there is an interplay of certain curative factors which may vary from group to group. There exists a distinct research void in this area.

### Concepts

Group therapy is the provision of therapy within a group setting. As described by Corey and Corey (1977), group therapy is a specific therapeutic group having the broad purpose "of increasing people's knowledge of themselves and others, assisting people to clarify the changes they want to make in their lives, and giving people some of the tools necessary to make these desired changes" (p. 6). Thus, there are many forms of therapeutic groups, including group therapy, group counselling, encounter groups, awareness groups, self-help groups and parenting groups, etc.,.

Parent training focuses on parents who desire to improve parent-child relationships. The role of parenting is recognized yet parents are viewed as unique individuals in their own right (Gordon, 1975).

② Curative factors. Most therapists agree that group change occurs due to specific forces operating within the group. These forces relate to outcome and are generally termed "Curative Factors" (Yalom, 1975). Yalom defined 12 such curative factors as follows: 1) 'altruism', 2) 'group cohesiveness', 3) 'universality', 4) 'interpersonal learning "input"', 5) 'interpersonal learning "output"', 6) 'guidance', 7) 'catharsis', 8) 'identification', 9) 'family reenactment', 10) 'self-understanding', 11) 'instillation of hope', and 12) 'existential factors' (p. 3). These are the factors which will be studied in this investigation.

Note (See Appendix A for qualifying comments on these concepts)



### Review of the Literature

The origins of group therapy have been described by many authors (Kaplan and Sadock, 1971; Rosenbaum and Berger, 1963; Mullan and Rosenbaum, 1962; Moreno, 1962; Gazda, 1968; Corsini, 1957; Yalom, 1975). Joseph H. Pratt (in Moreno, 1960) is generally considered the father of contemporary group therapy. In 1905 he undertook the treatment of a large number of patients with advance tuberculosis in a hospital setting. Later J. Moreno first used the term "group therapy" in 1931 and then "group psychotherapy" in 1932. Since then, many therapists have defined group therapy and group psychotherapy in many and various ways (see Corsini, 1957; Gibbs, Platts and Miller, 1951; Harms, 1944).

In general, group psychotherapy and group therapy are used interchangeably in current literature. Group therapy has become the shortened version of group psychotherapy (Gazda, 1968). Moreno (1962) chose a general definition for defining group therapy as "...Group therapy means simply to treat people in groups" (p. 263). To this day, this definition has been considered as the accepted one for various treatment professionals.

The issue related to the effectiveness of group therapy has been debated by many authors and therapists. In general, group therapy provides an atmosphere for

people to interact and learn from each other, which means certain individual and group changes are expected. Different therapists have identified the mechanisms of these changes.

For example, Corey and Corey (1977) considered the forces of change as "curative, healing, or therapeutic" (p. 18). Diedrich and Dye (1972) termed the changes measured in groups as "outcomes" and considered the change experiences as "growth producing" (p. 422). Similarly, Yalom (1975) considered therapeutic change as being "curative" and divided these changes into specific categories of curative factors, e.g., 'instillation of hope', 'universality', 'group cohesiveness', 'catharsis', 'guidance', and 'altruism', etc.,.

Many authors, researchers and therapists have studied the nature of these sorts of curative factors. A review of the literature in this subject area reveals that there are a diverse range of curative factors. Corsini and Rosenberg's (1955) widely cited work abstracted curative factors from about 300 group therapy studies in articles. One hundred and seventy-five curative factors were clustered into nine major categories. Subsequently, Yalom (1975) constructed 12 specific categories of curative factors which showed considerable overlap with the factors previously discovered by these therapists. His list appears

to be the most comprehensive and most widely recognized as curative factors.

Some studies have revealed the group members perceptions of curative factors operating in the group therapy process. For instance, Lieberman, Yalom and Miles (1972) investigated group members perceptions of the mechanisms of change in encounter groups. The surprising finding was the overall importance of some form of cognition in the process of change. For example, gaining insight and understanding about oneself was deemed relevant. This finding was surprising as 'Encounter Groups' are commonly viewed as "head trips" (Yalom, 1975, p. 86), rather than cognitive learning experiences. Other important items cited in their study were: insight, received advice, cohesiveness and recapitulation of family experience. These were deemed to be robust mechanisms of change.

Several studies have examined group members' perceptions of curative factors operating in group therapy (see Berzon, Pious and Parson, 1963; Dickoff and Lakin, 1963; Yalom, Tinklenberg and Gilula, 1975). All of these group studies refer to specific out-patient psychiatric services.

Berzon, Pious and Parson (1963) examined 18 members of two out-patient therapy groups after a course of 15 sessions. The major curative factors cited by these group members were related to group interaction. For example, recognizing similarity to other members in the group, feeling positive regard, acceptance and empathy for others, and seeing self



as seen by others, were cited as frequent outcomes of this study.

Yalom, Tinklenberg and Gilula (1975) studied the nature of curative factors operating in long term group therapy. Their major finding was that seven out of the top ten most helpful items to group members represented some form of catharsis or insight. This finding was consistent with Yalom's (1975) contention that group therapy is a dual process, consisting of both emotional experiences, and a reflection of those experiences.

Curative factors may be influenced by many variables. It is, therefore, important to examine the nature of certain curative factors which relate to group effectiveness. Thus, the remaining literature will be reviewed according to: 1) specific group therapies, 2) size of the group, 3) the stages of group therapy, 4) leadership, and 5) the physical setting for groups.

#### Specific Group Therapies

Different types of group therapies influence different types of curative factors. Every group therapy is made up of group members who have common problems. Thus, specific group therapies have specific goals, which are usually problem-centered.

For instance, Alcoholics Anonymous and Recovery Inc., (Wechsler, 1960) encourage the operation of 'Instillation of hope', 'Guidance', 'Universality', 'Altruism', and 'Group cohesiveness'. Other self help groups have similar

purposes. All promote the importance of sharing with other members who have a common problem. In this regard, group support is a vital component of the therapy.

A study by Lieberman, Yalom and Miles (1972) showed that some encounter group experiences are more effective than others in producing change. A central theme in Encounter group therapy is expression of feelings, feedback, insight, self-disclosure and discussion. Thus, different themes produce different change in different groups.

Abramowitz and Jackson (1973) conducted insight-oriented group therapy for 28 university students who were seeking improvement on social adjustment to university life. Their most important finding was that insight and group interaction are needed in order for change to be most significant.

Similarly, a study by Dickoff and Lakin (1963) studied out-patient psychiatric groups where the group purpose was supportive therapy. Group support, i.e., feeling liked, sharing emotional experiences with others, reducing loneliness and isolation, was the most important finding by these authors.

Weiner (1974) studied several groups of psychiatric patients where the goal of therapy was behavioral change. The most important finding of Weiner's study was that group members considered insight, catharsis, interpersonal learning "output", group cohesiveness, and existential factors to be most helpful.

Finally, one specific type of group therapy, namely Parent Training has been studied by several authors. One study found that educated parents often recognized the need for Parent Training more readily than less educated parents (Anchor and Thomason, 1977). In turn, educated parents simply enjoyed the intellectual stimulation and social interaction involved in partaking in Parent Training classes. A general feeling by many authors is that the parents' characteristics are likely to be predictive of the relative degree of success in Parent Training groups.

#### Group Size

A review of the literature suggests that the ideal size of a group generally depends on the group purpose. For instance, an intensive interactional group therapy suggests that a group size of seven members is ideal (Luchins, 1964; Yalom, 1975). Sensitivity training groups generally include more members, usually 12 to 16 members (Lieberman, Yalom and Miles, 1972). Still, group therapy forms such as Alcoholics Anonymous involve larger number of members and are still considered to be relatively effective.

There appears to be no "magic number" for a successful working group since so much depends on the purpose of the group, individual members and experiences of group leaders (Berelson and Steiner, 1964). In actual practice, the size of the group often depends upon the therapist's



expectations in view of the group purpose and his/her past experiences with groups. Although the size of therapy groups vary from 2 to 100, most groups range between 5 and 12 group members.

### The Stages of Group Therapy

Many researchers and clinicians feel that group members experience difficulty in rank ordering the importance of clusters of curative factors because various curative factors are helpful at different stages in the group therapy.

In the early stages of group therapy, the group is chiefly concerned with orientation of members and survival. Consequently, such factors as 'Instillation of hope', 'Guidance', and 'Universality' seem important (Yalom, 1975). The initial meetings of the group present a high risk period for dropouts or attrition. As the group member's needs and goals shift during therapy, so too, must the therapeutic process.

Specific curative factors such as 'Altruism' and 'Group cohesiveness' operate throughout group therapy, but their nature and importance changes through the course of therapy. For example, early in therapy, 'Altruism' generally takes the form of offering suggestions and helping one another, whereas later on in therapy it takes the form of offering more profound caring for one another. 'Group cohesiveness' operates early in therapy in the form of group support and acceptance, whereas later in therapy it permits group members

to engage themselves in the process of interpersonal learning.

Several researchers suggest exercising caution in evaluating findings of short term therapy which consists of less than 15 sessions. In retrospect, it seems more practical to look at the type of group therapy and its purpose for meeting prior to determining any sort of effectiveness or outcome.

### Leadership

It seems that leadership styles differ in the overall effects they produce in group therapy. Quite simply, some leadership styles are more successful than others.

Although a warm, accepting, democratic style is highly valued and used by a majority of group leaders, evidence suggests that there may be a highly individualized reaction to different leadership models (Gilbreath, 1967).

In regard to an individualized reaction to various leadership models, it is usually related to the personality of the therapist who leads or directs the group therapy. In other situations, it pertains to co-leaders or co-therapists. Since the early 1960's, the use of co-therapists in group therapy has become a well established practice. While there are a few dissenters (Slavson, 1966; Gans, 1962) the majority of therapists find the co-therapy model a useful one. Some of the strengths that have been cited in the literature in this regard range from: co-therapy providing role modeling (Mintz, 1963); an emotional experience for group members to see two

therapists acting and resolving individual differences in a constructive manner (Davis and Lohr, 1971); and decreasing anxiety in trainee therapists which has a direct bearing on therapeutic efficacy (Block, 1961).

On the other hand, some pitfalls may exist for co-therapists. Unless therapists predetermine their mutual roles and ensure their goals, styles and pace are compatible, the group therapy may suffer. Most problems among co-therapists normally emerge in long term group experiences (Davis and Lohr, 1971). One of the most important considerations for effective leadership appears to be the therapists willingness to communicate together and consider the importance of the quality of interaction. In this sense, effective leadership or co-therapy provides the framework for the existence of specific curative factors.

### Physical Setting for Groups

The physical setting for groups refers to the place where group members meet for therapy. Prior to convening a group, special attention should be given to the setting. Group meetings may be held in any setting. However, the setting should provide privacy and freedom from distraction for its members. Wolfe and Proshansky (1974) asserted that the freedom of choice of an individual to be involved in all group experiences is an essential one. Physical space must not only optimize the conditions for social interaction in the group but also provide an individual opportunity for privacy.



Another important aspect of setting refers to the physical seating arrangement of group members. Sociologists and social psychologists have shown clearly that seating arrangement relates to the communication patterns which impact on the satisfaction of individual members within the group experience (Goldstein, Heller and Sechrest, 1966). There is much laboratory type research as well as speculation to make one suspect that the seating arrangement and physical proximity of members may influence emotional response. Still, little research has been conducted in more naturalistic settings.

#### Summary

Many authors, researchers, and therapists have studied the nature of group therapy. All have identified the mechanisms of change which occur within the group process. A review of the literature reveals a diverse range of mechanisms of change or curative factors. Still, Yalom (1975) appears to have constructed the most comprehensive list of curative factors.

Curative factors cannot be considered as solely an entity in themselves. Rather, they are influenced by numerous variables. Several of these variables were cited and discussed in the literature review. They were as follows:

- 1) specific group therapies, 2) group size, 3) stages of group therapy, 4) leadership, and 5) physical setting for groups.

All of these variables seem to impact on the

effectiveness of group therapy and the existence of specific curative factors.

One of the recurrent findings from the literature review was that different types of group therapy impact on the importance of specific curative factors. Most of the literature reviewed related to out-patient psychiatric groups and outcome of intensive interactional group therapy. Still, several studies related to parenting which was the specific type of group therapy examined in this study. In this regard, it seems that Yalom's comprehensive list of curative factors could be applied to any type of group therapy.

### Theoretical Framework

This study purports to examine the outcome of three Parent Training groups. Twelve specific curative factors will be examined in these groups.

In the previous review of the literature, certain curative factors were deemed essential to group therapy. Yalom's (1975) research and method involving 12 curative factors will be used in determining parent effectiveness for this study. These factors form the basis for the theoretical framework of this study as their clinical relevance will be discussed (see Appendix B for a list of the 12 curative factors and a description of the 60 items which comprise the factors).

'Instillation of hope'. The instillation and maintenance of hope is important in group therapy. Not only is hope required to keep people motivated in therapy so that curative factors may impact, but faith in treatment can be therapeutically effective. Several research studies have demonstrated that a high pre-therapy expectation of help is significantly correlated with positive therapy outcome (see Goldstein, 1962, for example).

Therapy groups contain individuals who are at different points along a "coping-collapse" continuum (Yalom, 1975, p. 6). Group members have continued contact with group members who have improved in therapy. Group members also encounter members who had very similar problems to their own, and have coped with them effectively. Yalom (1975) found from his experiences with conducting group therapy,



that many group members at the termination of therapy have remarked how important it was for them to have observed the improvements of others. So too, group members often spontaneously disclose testimonials when new, unconvinced members enter therapy.

Some group therapies place a heavy emphasis on the 'Instillation of hope'. For example, a major component of Alcoholics Anonymous (AA) meetings is dedicated toward testimonials of hope. One of the greatest strengths of AA is the fact that all the leaders are ex-alcoholics and living inspirations to the other members. Group members often develop a strong conviction that they can be understood only by someone who has experienced the same problems as they had, and who has found help and coped with similar type problems.

No less important than group members' expectation of help in group therapy, is that the therapist has a belief in himself and in the effectiveness of the group. It is Yalom's (1975) contention that he is able to offer help and hope to any group member who commits himself/herself to therapy and remains with the group for at least six months. Yalom shares this conviction with his group members in his first meeting with them.

In many ways, 'Instillation of hope' is crucial to all types of group therapy. So too, it is a stepping stone toward building on the other curative factors.

'Universality'. Many individuals enter therapy with

the feeling that they have unique problems. 'Universality' relates to group members feeling that they are not alone as other members disclose concerns similar to their own. In the early stages of therapy, disconfirmation of feelings of uniqueness offers a powerful sense of relief for many. The group helps members perceive of their similarities as they relate to one another.

Despite the complexity of human problems, group members are not long perceiving their similarities when partaking in group therapy. An example of this may be illustrative. Members of T-group therapy were asked to write (anonymously) on a slip of paper their "top secret"--the one thing they would be most disinclined to share with the group (Yalom, 1975). The most common secret was a deep conviction of basic inadequacy--a feeling that if others really knew them, they would discover incompetence and see through their intellectual bluff.

'Universality' similar to the other curative factors cannot be appreciated alone or as a singular curative entity. For example, as group members perceive their similarity to others, and share their deepest concerns, they benefit further from catharsis and the ultimate acceptance by the other members.

'Altruism'. In group therapy, members not only think about themselves but consider each other. Members offer support, reassurance, suggestions, insight and share problems with one another. Yalom's (1975) findings indicated that psychiatric patients beginning therapy are demoralized

and possess a deep sense of having nothing of value to offer others. Rather, the therapeutic process helps psychiatric patients build their confidence and self-esteem because they find that they can be of importance to others. In a sense, group members benefit from the intrinsic act of giving.

In many ways, people need to feel that they are needed. By giving help to others, people feel they have something to offer others." 'Altruism' is a form of "actualizing" oneself. One forgets oneself by 'tuning-in' to the needs of someone else (Frankl, 1969). For example, consider ex-alcoholics who maintain their contacts with AA members after achieving years of sobriety. They give help to other alcoholics by the very fact that they have remained sober.

'Group cohesiveness'. This is a widely researched yet a basic property of groups. There are many methods of measuring cohesiveness and the precise definition depends upon the method employed. Yalom (1975) contended that 'Group cohesiveness' is "the resultant of all the forces acting on all the members to remain in the group" (p. 46). 'Group cohesiveness' simply means the attractiveness of group members to remain in the group.

Group members in group therapy consider cohesiveness to be a primary reason which helps in their therapy experiences. There is evidence to conclude that self-perceived positive outcomes are related to an individual's attraction to the group (Dickoff and Lakin, 1962; Kapp et al.,

1964; Yalom, Tinklenberg and Gilula, 1975; Yalom, Houts, Zimerberg and Rand, 1967; Clark and Culbert, 1965; and Lieberman, Yalom and Miles, 1972). Thus, highly cohesive groups generally have an overall higher outcome.

'Catharsis'. 'Catharsis' has always assumed an important role in the therapeutic process, though the rationale behind its use has varied considerably. For centuries, patients have been purged, to cleanse themselves of evil spirits. Freud (1935) and other psychotherapists learned the importance of 'Catharsis' in therapy. Yet, it has also been demonstrated that 'Catharsis' in and of itself did not promote individual change.

Lieberman, Yalom and Miles (1972) and Berzon, Pious and Parson (1963) illustrated the clinical limitations of 'Catharsis'. These authors suggested that members whose critical experiences consisted only of strong emotional experiences were not destined for a positive outcome. The most chosen items in Yalom's (1975) 'Catharsis' criteria conveyed a sense of something more than just an act of ventilation. For example, the items were: "Being able to say what's bothering me" and "Learning how to express my feelings".

'Catharsis' is an open expression of affect which is vital to the therapeutic process. Yet, it is only a part of the process and must be complemented by other curative factors.

'Guidance'. Under the heading of 'Guidance', Yalom (1975) included the didactic instruction about mental health,



mental illness, and general psychodynamics given by the therapist as well as advice, suggestions, or imparting of information about life problems offered either by the therapist or group members. When the therapist(s) or group members examined their experiences in interactional group therapy, they did not highly value the 'Guidance' curative factor. Yalom contended that the educational process is a very implicit one. However, most group therapists do not offer explicit didactic instruction in interactional group therapy.

There are, however, some group therapies which are organized along didactic lines, for example, Alcoholics Anonymous and Recovery Inc., (Wechsler, 1960). Groups in prenatal clinics for expectant mothers also use considerable didactic instruction (Burnett, 1964).

Didactic instruction can be employed in a variety of ways in group therapy. For example, to transfer information, to structure the group and to explain the group process. Often, it can function as the initial binding force in the group until other curative factors become operative. In addition to didactic information from the therapist, direct advice from the group members occur in each group. Also, some group therapies encourage the active participation of members. The sharing of information implies a mutual respect, interest, and legitimate caring for others.

Some groups make explicit and effective use of direct suggestions and guidance. For example, discharge groups

for psychiatric patients who are being prepared for discharge home from hospital. So too, Alcoholics Anonymous groups use slogans such as "one day at a time", "live and let live" which provide guidance and direct suggestions for everyday living.

'Family reenactment'. Some individuals enter therapy with a background of unsuccessful experiences. One of the most influential experiences is one's primary family. In many ways, group therapy can resemble a family. This becomes most apparent when the goals of group therapy are working out past problem areas in one's life and exploring relationships, which have not been successfully resolved. For example, a father who physically abuses his son and recalls being abused by his mother as a child may reflect back to his own childhood and his relationship with his mother as a means of understanding his specific problem with his son. So too, the group therapist may help this group member resolve some of his present problems by considering his early familial conflicts which were unsuccessfully resolved. Not all group therapies focus on this specific curative factor, yet in many groups, members often recall past childhood experiences and question how it affects their present lifestyle.

'Interpersonal learning ("input" and "output")'.

'Interpersonal learning' as understood by Yalom, Tinklenberg and Gilula (1975) is a complex curative factor, representing

several components of group therapy, namely: insight, intellectual awareness, and emotional expression.

'Interpersonal learning' relates to both "input" and "output" criteria and outcome. Yalom (1975) considered these factors as distinct from each other. More specifically, 'Interpersonal learning "input"' refers to the learning process where group members perceive and understand themselves. For example, the items stated: "Learning how I come across to others" and "Learning that I sometimes confuse people by not saying what I really mean". 'Interpersonal learning "output"' refers to the process by which group members learn through the "input" process with change occurring throughout therapy. For example, the items stated: "Feeling more trustful of groups and of other people" and "Working out difficulties with one particular member in the group".

Both these curative factors were highly valued by group members and therapists who were involved in interactional group therapy (Yalom, 1975). Still, not all group therapies value these curative factors. In general, the importance of 'Interpersonal learning' is dependent upon the nature of group therapy.

'Identification'. The importance of 'Identification' in group therapy is difficult to understand in a simple way. In group therapy, 'Identification' is diffused as group members may model themselves after other group members or the therapist(s).

In group therapy, it is not uncommon for a member to

clinically benefit by observing the therapy of another member with a similar problem. This is referred to as "vicarious" or "spectator" therapy (Moreno; 1939, p. 1). Even if specific imitative behavior is short-lived, it may function to help the individual "unfreeze" by trying out new behavior. In the Lieberman, Yalom and Miles (1972) study it was found that spectator therapy was important in short term encounter groups. Patients learned much from the solutions achieved by others who had similar problems to their own.

Rosenthal (1955) and later Sullivan (1959) described the impact of imitative behavior on psychiatric patients and their adoption of the value system of the therapist. These authors concluded that the importance of imitative behavior is dependent on the nature of group therapy.

A study of Yalom, Tinklenberg, and Gilula (1975) found that group members rated 'Identification' or imitative behavior as the least important curative factor. However, in retrospect, Yalom found that the five items on the 'Identification' scale, seem to have tapped only a small portion of the curative factor (see Appendix B for description of 'Identification' factor and these five items).

Thus, by recognizing the limitations of 'Identification' as described by Yalom (1975), as well as the difficulty in focusing in on what constitutes 'Identification', group members may tend to consider the factor less helpful to the group process. In addition, 'Identification' must be considered in light of the nature of group therapy.



'Existential factors'. Yalom, Tinklenberg and Gilula (1975) found that 'Existential factors' were ranked higher by group members than other factors such as 'Universality', 'Instillation of hope', 'Altruism', 'Family reenactment', 'Guidance', and 'Identification'. 'Existential factors' are described by five items (see Appendix B for details). These items are meaningful for group members as they arrive at painful truths about their existence. They realize that there are limits to the guidance and support others can give. In this context, there is a basic acceptance that life means facing some life experiences alone and for oneself.

'Existential factors' seem very pertinent to specific group therapies. For example, patients dying of terminal illness, spouses who are separated and alone, and the psychiatrically ill patients who are learning to cope in the outside world with few family supports, all are in need of catharsis. All realize that life means facing some life experiences alone and for oneself.

Still, all group therapies relate to real life situations. One goal of group therapy is learning how to live more effectively. Group therapy provides a situation where group members face a common problem yet they must also face their individual problems alone. Thus, depending on the type of group therapy and the individuals who make up the group, 'Existential factors' may be extremely important.

'Self-understanding'. 'Self-understanding' relates

to an intellectual component and self-awareness which plays a crucial part in the therapeutic process. There is much controversy regarding whether 'Self-understanding' produces change alone (Maslow, 1963; Berlyne, 1960; Dibner, 1958).

Yalom (1975) contended that 'Self-understanding' permitted people to change by learning new things about themselves. This referred to the intellectual understanding of the relationship between one's past and present, and was termed "genetic insight" (p. 92).

'Self-understanding' is linked to another curative factor, namely, 'Interpersonal learning "input"'. 'Interpersonal learning "input"' refers to gaining insight into how others perceive and understand us. In considering Yalom's (1975) study, both 'Self-understanding' and 'Interpersonal learning "input"' ranked high by group members in terms of being considered most helpful to the group process. More specifically, Yalom's study was focused on intensive interactional group therapy where the goal was towards self-understanding and interpersonal learning. Thus, the very nature of the group therapy set up the existence of the 'Self-understanding' factor as being helpful.

In summary, the 12 curative factors as construed by Yalom (1975) are building blocks essential to group therapy. Yalom's inventory of the curative factors were proposed from his extensive clinical experience, from the experiences of other therapists, from the views of successfully treated

group members, as well as relevant research on group therapy. Once identified, the factors are viewed as crucial to group therapy. From the review of the literature, many authors and therapists have identified change or outcome factors, yet Yalom clusters them into 12 curative factors.

Yalom (1975) also maintains that all curative factors exist in group therapy, yet specific factors are relevant to specific types of group therapy. So too, the factors are interdependent and can not function alone. Individual curative factors operate in every group therapy and the interplay of factors varies from group to group.

Furthermore, group members may benefit from different clusters of factors in the same group therapy. For at its core, therapy is a human experience, open to a number of interpretations by group members as well as therapist(s).

These 12 curative factors as presented by Yalom (1975), are the most comprehensive list of outcome factors to be organized and provide the theoretical and empirical framework to which group therapy in this study is evaluated.

## Method

### Setting and Population

Planned Parenthood Association of Newfoundland and Labrador with its central office in St. John's, Newfoundland provides the setting for this study. Planned Parenthood Association of Newfoundland and Labrador is an Association of Planned Parenthood Federation of Canada. It serves as the Newfoundland and Labrador provincial headquarters for public and professional education in birth planning, sexuality, and health which brings these needs to the attention of the community. The basic philosophy of Planned Parenthood is that family planning is a basic human right.

Planned Parenthood's provincial office in St. John's, Newfoundland, has a total of one full-time staff member, who functions as a clinic secretary and receptionist, as well as five part-time staff who include: a counsellor, a clinic nurse, a clinic co-ordinator, a program co-ordinator and a book keeper/secretary. Sixteen volunteers are also involved with the Planned Parenthood Board and Clinic Council in addition to 10 active volunteers, at large. In addition to the central office located in St. John's, a small Planned Parenthood office is located in Corner Brook, Newfoundland.

One of the many services provided by Planned Parenthood is educational and training programs for parents. Some of these programs include groups for single parents,



parent discussion, parent education, as well as seminars and workshops on various aspects of parenting and child care. This study examines one form of parenting group termed Parent Training. Parent Training (PT) was offered to the study sample in the Planned Parenthood office located at 21 Factory Lane in St. John's.

The physical setting of the Planned Parenthood Central Office consisted of ten small rooms in addition to one larger conference room which serves twenty-five persons comfortably. The Central Office was equipped with bathroom facilities, coffee room, a lounging area as well as a library which parents were encouraged to use, if they so desired. Several parents did borrow books and articles from the library which related to their parenting concerns. For example, sexuality, child management and discipline were specific concerns for several parents.

All PT sessions were held in the conference room of this agency. This room was carpeted, heated and well ventilated. The room was without windows, yet it was air conditioned with ample lighting. Adjacent to the conference room were bathroom facilities and a coffee room. All parents were seated in comfortable chairs arranged in a circle. Each parent was seated approximately one foot away from the other. The two co-leaders were seated in the group circle and away from each other. The co-leaders had accessibility to flip charts for presentation of any written material. All group members had access to tables,

which were located on both sides of the room. The group members used the tables for specific tasks, e.g., when they were completing the questionnaires and the evaluation forms. In view of the fact that the co-leaders arrived at Planned Parenthood office at 7:00 p.m., group members were informed that they could contact us by telephone, if they were unable to make a session.

The target population chosen for this study came from the St. John's Metropolitan area and smaller communities within a radius of 15 miles. In 1976, the population of St. John's was 143,390. Based on Statistics Canada (1978), there were 62,610 parents located in the St. John's area in 1976. As well, 3,355 parents were one parent family units and 59,256 constituted two parent family units.

#### The Sample and Procedure

An advertisement was first distributed in The Evening Telegram, the local daily newspaper published in St. John's, Newfoundland. The purpose of the advertisement was to invite all interested parents to attend a seven-week Parent Training group (see Appendix C for a copy of the advertisement). The advertisement was placed in the weekend edition of the newspaper on two occasions, one month before the Parent Training groups were scheduled to commence. This gave the group co-leaders ample time to plan the PT sessions in addition to conducting a pre-screening of group members for the groups. Information about the parenting groups was also solicited through social service agencies, hospitals, schools,

as well as Memorial University of Newfoundland.

The advertisement instructed all parents to contact the Planned Parenthood office or one of the co-leaders if they were interested in attending PT sessions. Those parents were then placed on a waiting list. The two group leaders randomly divided this list and then contacted each parent by telephone. Parents were then informed of the nature of the group and the tentative agenda for the seven group sessions.

The parents were informed that participation in the group required them filling out a set of questionnaires for research purposes. All parents were encouraged to bring their spouses to the group sessions. A nominal fee was charged for the group. Each parent was charged \$10.00 for the seven sessions. Attendance to all seven sessions was stressed at the onset, and the only requirement for attendance was that parents had at least one child within the age range of 5-12 years old.

From this list of interested parents willing to attend Parent Training sessions, two groups were subsequently formed. Parents were then randomly assigned to either a Wednesday or Thursday night group. These groups were called Group 1 and Group 2, respectively. Group 1 had a total of six parents; Group 2 had a total of seven parents. Any parents who were unable to attend the groups were placed on the waiting list. They were informed that other groups would be held in the future, and that they would be contacted accordingly.

Group 1 ( $n_1=6$ ) commenced May 20, 1981 for seven consecutive Wednesdays: May 20, May 27, June 3, June 10, June 17, June 24, and July 1. Group 2 ( $n_2=7$ ) commenced May 21, 1981 for seven consecutive Thursdays: May 21, May 28, June 4, June 11, June 18, June 25, and July 2.

A third Parent Training group was scheduled for September, 1981. All parents previously placed on the waiting list were contacted by telephone. Another advertisement was placed in the same local newspaper. The identical procedure for selecting parents for Groups 1 and 2 was used for Group 3 ( $n_3=8$ ). These Parent Training sessions commenced September 30, 1981 and ran for seven consecutive Wednesdays: September 30, October 7, October 14, October 21, October 28, November 4, and November 11. Again, any parents who were unable to attend the group were placed on a waiting list for future consideration.

At the onset, these parents all indicated an interest in attending the PT sessions. All parents were voluntary group members who confirmed their participation by paying a nominal fee of \$10.00 per person. All the parents indicated specific problems related to their children within the age range of 5-12 years. The total sample of parents was 21. Group 1 involved six parents; Group 2 involved seven parents; and Group 3 involved eight parents. Initially, Group 3 had ten parents, however, two dropped out after session one because they could not commit themselves to attending the seven ensuing sessions.

The Parent Training groups were co-sponsored and were run by two group leaders. Both leaders were female and



clinically experienced in conducting group therapy. The sessions ran for seven consecutive weeks (two hours per week) for a total of 14 hours of training. Each group session was scheduled for two hours with a ten minute coffee break in the middle of the session. The two co-leaders were present for all seven sessions in addition to inviting a specific guest speaker for sessions 2 through 6. In all, five guest speakers participated in the PT group therapy which was scheduled at the Planned Parenthood office at 21 Factory Lane, St. John's (see Appendix D for an outline of the format and content of these Parent Training sessions).

During the first PT session, an instrument in the form of a structured pre-test questionnaire was administered to all the participants. This instrument was a part of the other co-therapist's research (Vincent, 1982). The nature of the research was explained by the two co-therapists at this time. The participants were aware that it was generally related to PT. Factors such as confidentiality and respect for the privacy of individuals were also reviewed at this first session. The pre-test questionnaire of the other co-therapist took approximately 20 minutes for group participants to complete. In addition, all the participants completed the background and descriptive data which comprised part of the standardized instrument of this study. The group members completed the background and descriptive data section in approximately 15 minutes.

In session seven of the PT groups, the 60 item Q-sort questionnaire (Yalom, 1975) was administered to each group

member. Each member was given a stack of randomized cards and asked to place a specific number of cards into seven piles. The seven piles were labelled in the following manner:

1. Most helpful to me in the group (2 cards)
2. Extremely helpful to me in the group (6 cards)
3. Very helpful to me in the group (12 cards)
4. Helpful to me in the group (20 cards)
5. Barely helpful to me in the group (12 cards)
6. Less helpful to me in the group (6 cards)
7. Least helpful to me in the group (2 cards)

This procedure took approximately 20 minutes to complete. This represented ranking the 12 curative factors: 1) 'Instillation of hope', 2) 'Altruism', 3) 'Group cohesiveness', 4) 'Guidance', 5) 'Universality', 6) 'Catharsis', 7) 'Interpersonal learning "input"', 8) 'Interpersonal learning "output"', 9) 'Family reenactment', 10) 'Identification', 11) 'Self-understanding', 12) 'Existential factors', on a 7-point scale ranging from 'Most helpful' to 'Least helpful'.

In addition, at the end of session seven, the group members completed a separate evaluation form which was comprised of open and closed questions which evaluated the strengths and weaknesses of the PT sessions. This short evaluation form was construed by the two co-therapists and helped to critically evaluate the 'good' and 'bad' points of the group. Group members were encouraged to write any additional comments pertaining to the PT sessions on this form (see Appendix E for copy of the evaluation form).

### The Questionnaire

The final questionnaire (see Appendix B) was composed of both self-report standardized and non-standardized items and measures. The questionnaire had two sections which were categorized as follows:

Part 1 (i) General background questions----demographic variables identified in this section were sex, age, marital status, number of times married, race, place of residence, (ii) Occupational background----included employment status, the highest occupational level ever achieved, and the longest period of time that the respondent had a steady job, (iii) Educational background----included the highest educational level ever attained (Hollingshead, 1957), (iv) Family background----included the number, ages and sex of children in the family, (v) Group therapy background----this included the group member's participation in other Parent Training sessions.

The only computed variable in Part 1 was socioeconomic status (SES). This was calculated according to the standardized summative score of the two variables, occupational background and educational background (Hollingshead, 1957), yielding five SES classes ranging from 1-V (see Guy, 1976, p. 80, for a more specific breakdown of the scoring of this variable).

Part 11 consisted of a standardized measure called Q-sort questionnaire. The instrument consisted of 60 items. Twelve categories of curative factors were constructed from the sources outlined in Yalom (1975). Five items described

each curative factor which made a total of 60 items. All 60 items are listed in Appendix B. Each item was typed on a 3 x 5 index card which totaled 60 cards. All group members were given a stack of randomized cards and instructed to place a specified number of cards into seven piles, labelled as previously discussed on page 35.

In view of the forced choice ranking of the 60 items into seven specific piles, the mean score of the 60 items would be 4.00. Pile 4 refers to the 'Helpful' level whereas any score less than 4.00 would be considered either 'very', 'extremely', or 'most' helpful to the group members. A score of more than 4.00 would be considered either 'barely', 'less', or 'least' helpful to the group members.

The Q-sort questionnaire used in this study had acceptable to high degrees of internal consistency reliability (see Yalom; 1975, for details of the questionnaire and its reported reliability and validity estimates).

The pre-testing of the questionnaire. The questionnaire previously described was pre-tested in July, 1981 on a Parent Training group of six parents who attended seven sessions at the Department of Social Services, Juvenile Corrections Division, in St. John's, Newfoundland. All group members who attended the PT group were parents with at least one child considered a "juvenile delinquent". All group members were informed and aware of the purpose of the questionnaire prior to the co-leaders administering it. All parents completed the general background questions in session one of PT. In session seven, the co-leaders



administered the 60 item Q-sort questionnaire to all six group members of the PT group. This pre-test helped refine the questions and the way in which the questionnaire was administered for this study.

This group was not part of the study sample, rather was considered as being a pilot group.

## Results and Discussion

The results and discussion of the data are presented according to the following two sections: 1) Background and Descriptive Data and 2) The Q-sort Analyses.

### 1. Background and Descriptive Data

The 21 parents who comprised the study sample ( $n=21$ ) ranged in age from 27-51 years. Sixteen were female and five were male. The mean age was 34.2 years. All were Caucasian and had never participated in Parent Training groups before.

In regard to marital status, 4.7% reported that they were divorced and 95.3% indicated that they were married. Of those who were married, 100% indicated they were married once.

In regard to residence, 47.6% of the sample indicated that they lived in a small city most of their life, specifically St. John's, Newfoundland, Canada. Thirty-eight percent reported they lived in rural Newfoundland, 9.5% reported they lived in a large city, and 4.9% reported they resided mainly in the suburbs of St. John's.

In terms of employment status, 42.9% indicated they were currently employed and 57.1% indicated they were unemployed. The highest occupational level ever achieved by the parents was categorized as 'higher executive, major professional', which described 4.8% of the sample. Another 4.8% reported an occupational attainment of

'business manager or proprietor of a medium-sized business'; 19% reported an occupational attainment of 'administrative personnel, owner of a small independent business or minor professional', and 14.3% reported an occupational level of 'skilled manual employee (or blue collar employment)'.

Most of the sample (57.1%) reported an occupational level categorized by 'clerical or sales worker, technician or owner of a little business'. The average longest period of time that an individual in this sample held a steady job was 7.3 years. The range from which parents held a steady job was 2½ to 20 years.

In regard to educational level, 19% reported graduate or professional training, 9.5% reported achieving college graduation, 42.9% reported some college or technical school graduation, 19% reported high school graduation, 4.8% reported some high school and 4.8% reported a junior high school educational level.

The Socioeconomic Status (SES) of the sample was broken down in Table 1 as follows:

Table 1

The Socioeconomic Status (SES) for the Sample of Three Groups of Parents Involved in Three Parent Training Groups ( $\underline{n}=21$ )

Social* Class	Group 1 ( $\underline{n}_1=6$ )	Group 2 ( $\underline{n}_2=7$ )	Group 3 ( $\underline{n}_3=8$ )	Total of the 3 Groups ( $\underline{n}=21$ )
I	0.0%	14.3%	0.0%	4.8% (n=1)
II	16.7%	28.6%	12.5%	19.0% (n=4)
III	0.0%	57.1%	50.0%	38.1% (n=8)
IV	83.3%	0.0%	37.5%	38.1% (n=8)
V	0.0%	0.0%	0.0%	0.0%
Total	100.0%	100.0%	100.0%	100.0%

Note (\*) As indicated by A. B. Hollingshead (1957).



The average number of children per family, their sex, and age range in years is indicated in Table 2 below:

Table 2

Characteristics of the Children ( $n=50$ ) of the Parents who were from the Three Parent Training Groups

Sex	Average number per family	Average age in years	Age range in years
Female	1.28	6.5	2-16
Male	1.14	8.5	3 $\frac{1}{2}$ -16
Total	2.42	7.5	2-16

Table 2 reveals that the parents generally had small families with few children. The average family unit for the parents in the study had two children with an equal number of males and females. Although the focus of the PT groups was directed toward parents with children from 5-12 years, there was some overlap into other age categories. For example, children of ages two, three, and four were considered pre-schoolers, whereas children of ages 13, 14, and 15 were considered adolescents. Children in either of these age groups, therefore, would have their own specific problems.

### Discussion of Background and Descriptive Data

The parents who attended the PT groups were relatively heterogenous in many respects. The group members ranged in age from 27 to 51 years with a  $\bar{x}$  age of 34.2 years. Of the 21 parents, 16 were mothers and five were fathers. All of the sample were Caucasian and had never previously attended a Parent Training group. Thus, the sample was fairly young, and predominately female.

The regional bias might explain why all parents were Caucasian. Since the population of St. John's is predominately Caucasian (96%), the data was not surprising. Most of the group members were female which is also not surprising. Group therapy is relatively new in the province of Newfoundland and of those who attended, women seem more open to accepting this treatment modality. As well, the PT groups were held in a local Planned Parenthood office which was used predominately by females.

Over half of the parents who attended PT were employed and all who were unemployed were women. Many women in the group issued specific concerns related to the issue of working outside the home. For example, some women who were employed outside the home indicated that they were working out their feelings about this issue. For those women who stayed home to raise their families, many indicated that they were satisfied, yet all wanted to return to the work force in the future.

Of the ten parents who were employed, five were female.

This may imply a somewhat traditional view toward parenting. More specifically, women "should" stay home and raise their children, while men work. Considering the relatively homogeneous and tradition bound culture of Newfoundlanders in general, this finding is not surprising. All five men who attended PT group were employed, whereas only five of the sixteen females were employed.

Another finding worth noting was that the men generally felt "less willing" and "more anxious" in attending the PT sessions than the women. The initial aim of PT was to have couples attend, yet many of the husbands contacted were unable to commit themselves to the sessions. Several reasons could be offered to explain this: 1) men felt that parenting was a women's concern because they spent most of the time with children, 2) most of the men who tried the initial PT sessions felt uncomfortable because they were often surrounded by a group of women, and 3) most of the women who attended the PT sessions expressed that their husbands were either not interested, or motivated to discuss parenting concerns.

As well, the women tended to enjoy the company of other women who could more readily empathize with them. For example, one woman disclosed many more problems when her husband did not attend the sessions, and she openly admitted to feeling embarrassed by her husband's presence.

The group members who attended the PT sessions lived in two different and distinct areas of Newfoundland. Eleven parents lived in St. John's (the capital city) most of

their lives and seven lived in rural environments. Parents who lived in rural environment, lived approximately 15 miles from St. John's, and were enthusiastically motivated to attend the PT sessions. Another finding worth noting was that these rural parents had less support services available in their respective communities. For example, they all recognized and noted the lack of support services in their environments and were hoping to find some answers to these problems at the PT sessions.

Most of the parents (90%) had a minimum of high school graduation. The Socioeconomic Status (SES) of the sample revealed a predominately middle-lower class group of parents. There were no parents in the lowest SES class, however, Classes IV and III had the highest percentage of endorsement (Hollingshead, 1957). These results generally indicated a middle-lower class group of motivated parents with high parental expectations. This finding was similar to a study conducted by Anchor and Thomason (1977) where these researchers determined that the parents who attended PT were all of middle-class status. These investigators hypothesized that parents who volunteered to attend PT groups were normally educated parents. This study therefore, supported the findings of Anchor and Thomason (1977).

Gazda et al., (1975), also reported similar results to the findings of Anchor and Thomason (1977) yet suggested an intriguing explanation for why educated parents were motivated to attend PT groups. They reported that participation may reflect a general inclination toward being



active in community affairs. Thus, consistent with the previous literature which suggested a relationship between educational level and PT participation, this study also supported this finding.

The group members indicated an average of two children per family with an equal number of boys and girls. The age range of their children was 2-16 years, and each group member had at least one child between the ages of 5-12 years. The relatively small number of children per family was not that surprising considering the average age of the parents (34.2 years).

In summary, the sample of this study were motivated, educated middle-lower class parents, specifically mothers who wanted to be better parents. The sample was not necessarily representative of the general population of parents residing in Newfoundland, but was also not that different from the general population, nor what was expected.

#### 11. The Q-sort Analyses

The major standardized instrument used to determine curative factors in this study was the Q-sort questionnaire (Yalom, 1975). See Method section of this study (pp. 34-36) for a detailed explanation of this instrument. The Q-sort provided information about 12 specific curative factors apparent in this study. These factors are ranked in descending order in Table 3.

Table 3

The Ranked Means in Descending Order of the 12 Curative Factors in the Q-sort Analysis (n=21)

Group 1 (n=6)			Group 2 (n=7)			Group 3 (n=8)		
Curative Factor	Mean Score	S.D.	Curative Factor	Mean Score	S.D.	Curative Factor	Mean Score	S.D.
1. Altruism	3.00	1.13	Altruism	2.97	1.45	Instillation of hope	2.85	1.30
2. Group cohesiveness	3.20	1.80	Group cohesiveness	3.31	1.22	Group cohesiveness	3.25	1.08
3. Instillation of hope	3.30	1.55	Universality	3.46	1.45	Catharsis	3.50	1.01
4. Universality	3.50	1.50	Instillation of hope	3.49	0.61	Altruism	3.75	1.29
5. Catharsis	3.67	1.32	Catharsis	3.52	1.07	Universality	3.76	0.92
6. Guidance	3.93	1.48	Guidance	3.81	1.18	Guidance	3.85	1.32
7. Interpersonal learning "output"	4.17	1.03	Interpersonal learning "output"	4.19	1.61	Interpersonal learning "output"	3.95	1.62
8. Identification	4.47	1.08	Self understanding	4.54	1.97	Self understanding	4.32	1.22
9. Existential factors	4.49	0.92	Identification	4.57	1.02	Identification	4.50	1.02
10. Self understanding	4.53	1.25	Existential factors	4.59	1.22	Family reenactment	4.51	1.14
11. Family reenactment	4.66	1.36	Interpersonal learning "input"	4.74	1.20	Interpersonal learning "input"	4.60	0.98
12. Interpersonal learning "input"	5.13	1.38	Family reenactment	4.80	1.17	Existential factors	5.09	1.21

Table 3 depicts the similarities between Group 1, Group 2, and Group 3 in regard to what group members perceived as helpful/curative factors. The rank ordering of the twelve curative factors indicated that specific curative factors were more helpful than others.

For example, Group 1 and Group 2 ranked 'Altruism' as the most helpful curative factor in contrast to Group 3 which ranked 'Instillation of hope' as being most helpful. However, the three groups ranked six specific curative factors as generally being helpful to all of them. These six most helpful curative factors, which had a mean of 4.00 or less, were as follows: 1) 'Instillation of hope', 2) 'Altruism', 3) 'Group cohesiveness', 4) 'Catharsis', 5) 'Universality', and 6) 'Guidance'.

Due to the fact that the responses are not discernibly different for the three groups on the initial Q-sort Analysis, the data will be combined for subsequent analyses. Table 4 represents the rank ordered means for the overall sample of the three Parent Training groups of the study.

Table 4

The Overall Ranked Means in Descending Order of  
the Curative Factors for all Three Groups Combined ( $n=21$ )

Rank	Curative Factors	Mean $\bar{X}$	Standard Deviation S.D.
1.	Instillation of hope	3.21	1.35
2.	Altruism	3.24	1.33
3.	Group cohesiveness	3.25	0.94
4.	Catharsis	3.56	0.43
5.	Universality	3.57	1.10
6.	Guidance	3.86	1.32
7.	Interpersonal learning "output"	4.10	1.46
8.	Self-understanding	4.46	1.47
9.	Identification	4.51	1.00
10.	Family reenactment	4.65	1.19
11.	Existential factors	4.72	1.15
12.	Interpersonal learning "input"	4.82	1.27



As indicated in Table 4, all of the curative factors deemed as being most helpful to the Parent Training groups had  $\bar{x}$ 's less than 4.00. A further breakdown of the respective items of the Q-sort (which comprised the factors or dimensions) deemed as being most helpful to the three groups were reported in Table 5.

Table 5

The Eleven Most Important Items Deemed as Being Most Helpful to the Groups  
( $n=21$ )

Rank	Item (number and description)	Mean $\bar{x}$	Standard Deviation S.D.
1.	(11) Learning that I'm not the only one with my type of problem; we're all in the same boat.	2.57	0.98
2.	(55) Knowing that the group had helped others with problems like mine encouraged me.	2.76	1.18
3.	(53) Seeing that others had solved problems similar to mine.	2.90	0.77
4.	(31) Getting things off my chest.	2.95	1.16
5.	(29) Someone in the group giving definite suggestions about a life problem.	2.95	1.38
6.	(52) Knowing others had solved problems similar to mine.	3.00	1.38
7.	(10) Belonging to a group of people who understood and accepted me.	3.05	0.81
8.	(35) Being able to say what was bothering me instead of holding it in.	3.05	1.07
9.	(8) Revealing embarrassing things about myself and still being accepted by the group.	3.19	0.72
10.	(4) Giving part of myself to others.	3.19	1.12
11.	(2) Putting others' needs ahead of mine.	3.19	1.58

These eleven most helpful items cited in Table 5 were consistent with the findings previously reported in Table 4. For example, all eleven items related to the six most important curative factors ranked in Table 4.

Item 11 referred to 'Universality'; Items 52, 53, and 55 referred to 'Instillation of hope'; Items 31 and 35 referred to 'Catharsis'; Items 8 and 10 referred to 'Group cohesiveness'; Items 2 and 4 referred to 'Altruism'; and Item 29 referred to 'Guidance'.

The 60 item, seven pile Q-sort for twenty-one subjects can be construed and analysed from a number of perspectives. Perhaps the clearest way to consider the results is a simple rank ordering of the sixty items (see Appendix F). In this regard, the number after each item represents its rank ordering. Thus, Item 11 ("Learning I'm not the only one with my type of problem; We're all in the same boat"), was considered the most important curative factor item by the consensus of group members; Item 19 ("Group members pointing out some of my habits or mannerisms that annoy other people"), the least important, and so on. A 'Tie' or 'T' represents a tied score.

#### Discussion of the Q-sort Analyses

The data indicated that all three Parent Training groups had similar findings on the Q-sort analyses. The groups focused on certain curative factors as being more helpful than others (see Table 3, p. 47). Table 3 revealed some

variation in the rank ordering of the 12 curative factors. For example, 'Altruism' was ranked as the most helpful curative factor in Group 1 and Group 2, versus 'Instillation of hope', which was ranked first in Group 3. This finding can be construed from several points of view.

First, the members from Group 3 attended the Parent Training sessions approximately sixteen weeks after Groups 1 and 2. The group co-leaders had subsequently acquired some clinical experience in conducting the PT groups from their experiences in training Groups 1 and 2. Thus, the group co-leaders felt more confident and prepared for the final group (Group 3). It seems plausible, therefore, that the 'Instillation of hope' factor was considered by group members as the most helpful curative factor, in that the therapist empathized and indicated more hope for their members.

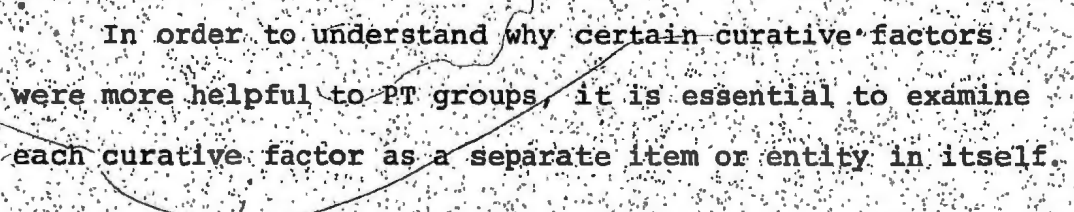
Second, Group 3 was a larger group ( $n_3=8$ ) compared to Group 1 ( $n_1=6$ ) and Group 2 ( $n_2=7$ ). More importantly, the subjects of Group 3 presented more problems and frustrations than did those parents in the other groups. Consequently, Group 3 tended to focus on their respective problems more so than the parents in Group 1 and Group 2. Thus, 'Instillation of hope' was seemingly important to Group 3 because they expressed more problems/frustrations and were looking for help.

In contrast, the parents of Groups 1 and 2 tended to focus less on their individual concerns but rather on the problems of other parents in the group. These parents



tended to express less problems than the parents in Group 3. Consequently, they tended to empathize more with the other parents and thus considered 'Altruism' as the most helpful curative factor.

Despite this finding, the data are similar for the PT groups (see Table 3) and consequently, are treated as one data set or one overall group for the subsequent discussion. Table 4 (p. 49) reveals the overall ranking of curative factors for the three groups. It was determined that the most helpful curative factors had a  $\bar{x}$  less than 4.00. The six curative factors that were deemed as being most helpful to the groups were (in descending order): 'Instillation of hope', 'Altruism', 'Group cohesiveness', 'Catharsis', 'Universality', and 'Guidance'.

The remaining six factors had a  $\bar{x}$  score greater than 4.00 which suggested that they were less helpful to the group. Since a  $\bar{x}$  score of 4.00 was considered in the 'Helpful' pile of the Q-sort, any  $\bar{x}$  score greater than 4.00 was moving toward the 'Barely helpful' pile of the Q-sort (see Method Section, p. 35, for an interpretation of the mean scores). The six factors considered of less importance were (in descending order): 'Interpersonal learning "output"', 'Self-understanding', 'Identification', 'Family reenactment', 'Existential factors', and 'Interpersonal learning "input"'.  


In order to understand why certain curative factors were more helpful to PT groups, it is essential to examine each curative factor as a separate item or entity in itself.

The ensuing discussion, therefore, will interpret these individual curative factors as they were ranked in terms of degree of importance.

'Instillation of hope'. This was deemed the most helpful curative factor for the Parent Training groups. Thus, group members placed a heavy emphasis on hope more so than other factors. All parents who attended PT had specific problems with their children and met other parents who expressed similar problems.

Items 52, 53, and 55 were all considered by group members as being very helpful in this regard. Item 52 was "Knowing others had solved problems similar to mine", Item 53 was "Seeing that others had solved problems similar to mine", and Item 55 was "Knowing that the group had helped others with problems like mine encouraged me". All three of these items related to parents knowing other parents in the group who had solved similar problems to their own. This, therefore, encouraged parents to hope for help or solutions to their problems.

In the PT groups, resource persons spoke on special topics of interest to parents which may have offered hope to the group members. For example, the guest speakers were professed 'experts' in specific child-parent fields and provided some answers and possible solutions to specific problems that parents had experienced. The co-leaders also encouraged group members to make use of community resources to help with specific parenting concerns.

In the groups, the parents were generally at different levels of coping with their problems. Thus, some parents were models for others and provided hope and inspiration. For example, in many instances, parents talked about improving in specific parent-child problem situations because they tried out suggestions or listened to how other parents coped with similar problems. Thus, it seemed logical that 'Instillation of hope' which transferred from experts, co-leaders, and other parents to all parents in the group was ranked highly for this sample.

'Altruism'. One of the obvious features of the Parent Training groups was that all of the group members were parents. Thus, all of the parents readily identified problem situations and also wanted help for their problems. Table 4 (p. 49) revealed that 'Altruism' was ranked as the second most important curative factor for the sample of 21 group participants.

Because of the focus of this group therapy, all of the parents expressed specific problems in regard to their children and family. Some parents had already faced specific problems which they presented to the group. They had solved or dealt with these problems previously, thus they were able to help other parents who expressed these types of problems.

The altruistic notion of helping other parents was particularly apparent with parents of older children who empathized with parents who had problems with younger children. These parents offered concerned support, re-

assurance and suggestions to the less experienced parents.

'Group cohesiveness'. This was ranked by the group members as the third most helpful curative factor. 'Group cohesiveness' refers to the attraction that members have for their group and for other members. Items 8, 9, and 10 were all rated as important to the PT groups. Item 8 was "Revealing embarrassing things about myself and still being accepted by the group", Item 9 was "Feeling alone no longer", and Item 10 was "Belonging to a group of people who understood and accepted me".

From the previous literature review, it was determined that members of cohesive groups are more accepting of one another, more supportive and more inclined to form meaningful relationships in the group. Thus, cohesiveness seems to be a significant factor in group therapy outcome for producing group acceptance, group support, intermember trust, and acceptance in helping each other.

For example, Yalom, Tinklenberg, and Gilula (1975) tested the importance of 'Group cohesiveness' in the group therapeutic process. Their results indicated that attraction to the group is indeed a strong determinant of outcome. Groups with higher overall levels of cohesiveness had significantly higher overall outcomes than those with low cohesiveness. Again, it was not surprising that the data of this study indicated the importance of 'Group cohesiveness' because all group members were attracted to each other and the group, as they were all parents with common parenting concerns.



'Catharsis'. This factor was ranked as the fourth most helpful curative factor by group members. Because of the nature of the group, all group members were given ample opportunity to talk about their problems. Consequently, the parents were encouraged to discuss their problem situations and talk about their feelings and frustrations of being a parent. The parents were not judged as being good or bad, but rather, were encouraged to open up to other parents.

Items 31, 34 and 35 were ranked as highly helpful to group members in this context. Item 31 was "Getting things off my chest", Item 34 was "Learning how to express feelings", and Item 35 was "Being able to say what was bothering me instead of holding it in". Thus, these items seemed to convey a sense of liberation and of acquiring skills for future use. Furthermore, this factor had a direct effect on the importance of the overall group cohesiveness. Members who expressed their feelings and problems developed trust and acceptance toward achieving a deeper bond to the other members of the group.

'Universality'. This was ranked as the fifth most helpful curative factor by group members. All members were parents with at least one child between 5-12 years old. They all expressed concerns related to specific child rearing situations. Thus, the group members were not alone as they were parents with similar life stresses and experiences.

From the PT groups, Items 11, 12 and 13 were ranked the most helpful in this regard. Item 11 was "Learning I'm not the only one with my type of problem; We're all in the same boat", Item 12 was "Seeing that I was just as well off as others", and Item 13 was "Learning that others had some of the same 'bad' thoughts and feelings I do".

As parents perceived of their similarities to other parents in the group and shared their deepest concerns, they benefited further from catharsis and ultimate acceptance ('Group cohesiveness'). The 'Universality' factor was also apparent. Yalom's (1975) research supports this finding. In group therapy, particularly in the early stages, the disconfirmation of group members' feelings of uniqueness is a powerful source of relief. After hearing other members disclose concerns similar to their own, group members reported feeling more in touch with the world and described the process as a "welcome to the human race" experience (Yalom, 1975, p. 8).

Guidance. This factor ranked as the sixth most helpful curative factor. 'Guidance' was provided in several ways: 1) guest speakers who were professed 'experts' in specific child rearing situations provided concrete advice to the parents, 2) the guest speakers related their own personal experiences from their professional clinical practice as well as their own family experiences, 3) the co-leaders provided guidance for parents by providing definite suggestions to their problems, and 4) the group members provided

suggestions and advice to other parents for specific life problems. Thus, not surprisingly, the guidance/counselling theme of the group therapy seemed to be an important factor for the study sample.

In this context, items 27 and 29 were ranked as the most helpful guidance-oriented items. Item 27 was "Group members suggesting or advising something for me to do", and Item 29 was "Someone in the group giving definite suggestions about a life problem".

Several studies in the previous literature review considered 'Guidance' as being simply an imparting of information. This included advice, suggestions, or direct guidance given by the therapist(s) or group members. In specific types of group therapy, group members and therapists did not highly value this curative mode (for example, in Yalom's 1975 study where the focus was interactional group therapy). In other types of group therapy, 'Guidance' unfolded as an important factor. For example, discharge groups where members were being prepared for discharge from hospital (Lieberman, Yalom and Miles, 1972) and parenting groups where the focus was educational (Gordon, 1975).

'Interpersonal learning "output"'. This factor ranked as the seventh most helpful curative factor to the group members. This specific curative factor was helpful to the PT groups as parents seemed to consider specific items as being important. Items 21 and 22 were ranked as the most pertinent items to 'Interpersonal learning "output"' for PT.

Item 21 was "Improving my skills in getting along with people", and Item 22 was "Feeling more trustful of groups and of other people". Thus, the PT groups may have given the parents some confidence in improving their interactive skills in the group therapy sessions. In retrospect, the nature of the Parent Training did not set up the importance of this specific factor because the parents were focusing on their life problems, rather than depending on feedback from the group members which related to their interactive skills.

From the previous literature review, it became apparent that 'Interpersonal learning "output"' was most helpful to specific types of group therapy namely, intensive psychotherapy where group members worked through their personal problems through their relationships with other group members. The focus of this type of therapy was insight directed as well as intellectual understanding. Yalom (1975) provided the most comprehensive findings of group therapy of this nature, which considered 'Interpersonal learning "output"' more helpful to group members.

'Self-understanding'. This relates to the intellectual component in encouraging people to recognize, integrate, and give free expression to one's feelings and ideas. This curative factor was ranked as the eighth most helpful factor in this study sample.

The PT groups were not specifically directed toward self-understanding but rather, understanding the self in regard to specific life problems. For example, Item 47



was ranked as the most important item in relation to the 'Self-understanding' factor. Item 47 was "Learning why I think and feel the way I do (i.e., learning some of the causes and sources of my problems)".

'Interpersonal learning "input"' and 'Self-understanding' were two curative factors which related to specific intellectual insight-oriented components. Both of these curative factors were ranked lower than others by the group members. More specifically, 'Self-understanding' referred to understanding one's past and present behavior and gaining some insight into one's apparent problems. For the PT groups, the focus was not on insight but rather on information getting and discussion. Thus, its lower rank ordering was not surprising.

'Identification'. This factor was ranked as the ninth most helpful in the overall sample. 'Identification' was not apparently relevant where it referred to parents wanting to be like someone else in the group. The only item important to the parents in this context was Item 37: "Seeing that others could reveal embarrassing things and take other risks and benefit from it helped me to do the same". In a sense, this item referred to parents learning from watching the process of other parents working. This provided hope for parents in solving or dealing with their problems.

One may speculate that the PT groups did not seemingly reveal 'Identification' for some possible

reasons: 1) the group co-leaders were not parents, thus they could not be considered as models for the parents attending the group sessions, 2) few parents were 'model' parents, because they all identified specific or similar problems in which they needed help, and 3) the guest speakers were experts in specific parent-child fields, yet each guest speaker spent only one hour participating in the PT sessions. Thus, their impact as 'models' was minimized. In addition, the guest speakers tended to be professed 'experts', and they were not on the same level as the group members.

In view of the five items describing 'Identification', it seemed that only a limited sector of this curative factor was tapped (see Appendix B for a description of the five items). The factor tended to concentrate on adopting mannerisms of other parents or the therapist(s). In many ways, group members had no specific item which would relate to "spectator therapy" (Yalom; 1975, p. 97). This refers to group members learning from observing or listening to the solutions achieved by others who have similar problems to their own.

Lieberman, Yalom, and Miles (1972) found this form of identification to be most helpful to group members partaking in short term encounter groups. So too, spectator therapy would no doubt occur in Parent Training groups. Unfortunately, no specific item tapped this

aspect of 'Identification'.

'Family reenactment'. This ranked as the tenth (of twelve) most helpful curative factor. All of the group members entered therapy with a history of unsatisfactory experiences in their first and most important reference group, their family. The group resembled a family in some respects, yet did not act like a family in another sense.

The groups did not focus on individual growth but rather educational/information issues. The fact that the 'Family reenactment' factor was not cited as helpful by the parents is not surprising, since it is operative on a somewhat different level of awareness from such explicit factors such as 'Universality', or 'Catharsis'. Since the groups did not focus explicitly on this factor, it did not seem pertinent to its overall outcome.

'Existential factors'. Not surprisingly, 'Existential factors' ranked as the eleventh most helpful curative factor. In fact, 'Existential factors' were not important at all to the group members. Parents were not 'tuned-in' to these feelings and realities of life. For example, Item 60 was cited as the most helpful of the five items pertaining to 'Existential factors', yet it was ranked 35 out of the 60 possible items. Item 60 was "Learning that I must take ultimate responsibility for the way I live my life no matter how much guidance and support I get from others".

Because of the nature of the PT groups, the parents tended to focus on other positive facets of their lives. They all had to face similar or unique problems as parents, yet parenting was generally viewed in a positive light. In addition, the parents were supported in numbers because of the group therapy experiences. Subsequently, 'Existential factors' were not emphasized nor deemed as relevant to the Parent Training groups.

'Interpersonal learning "input"'. Finally, 'Interpersonal learning "input"' was ranked as being least helpful to the groups. 'Interpersonal learning "input"' is a complex curative factor which is very crucial to specific group therapies. It has a focus on interpersonal interaction. Parents in the PT groups were generally not internalizing their intrapsychic selves, but rather dealing with their specific parenting concerns.

There were very few incidents of the group members in PT confronting each other as to what they thought of each other, or how they interacted with other group members. 'Interpersonal learning "input"' referred to group members gaining insight and understanding about themselves through feedback from the group process. Rather, the PT groups were focused on providing information relating to specific parent concerns within a supportive milieu.

Although it was important to examine each curative factor as an individual entity, it was apparent from Table 4 (p. 49) that some overlap existed among the various



curative factors. The  $\bar{x}$  for the most helpful curative factor was 3.21 whereas the  $\bar{x}$  for the sixth most helpful curative factor was 3.86. This difference was minimal, only .65 on a seven-point scale.

In addition, the remaining six curative factors were ranked from seventh to twelveth in their relative degree of importance. The overall  $\bar{x}$  was 4.10 for the seventh factor and 4.81 for the twelveth most important curative factor, respectively. This difference was only .71 on a seven point scale.

### Summary

The results of the Q-sort questionnaire for the PT groups provided important information which can be readily summarized according to general comments, findings of other parenting groups, and findings of other relevant studies.

General comments: First, the nature and type of group therapy was reflected in the outcome factors deemed as being more important than others. The PT groups were not offering intensive psychotherapy for parents, but rather were intended to provide educational input for parenting and gave parents an opportunity to discuss their concerns. The PT groups were primarily educational/discussion focused and formulated.

Second, during the course of therapy (for all three groups) more problems unfolded in the latter

sessions. In this regard, the length of time for group therapy can be construed as an independent variable which influenced the parents' ability to reveal information about themselves. Thus, more group sessions would give parents more time and opportunity to reveal more problems and information about themselves.

Third, the size of the PT groups seemed to impact on the effectiveness of the group therapy sessions and outcome factors. For example, all of the PT groups were small in numbers ( $n_1=6$ ), ( $n_2=7$ ), ( $n_3=8$ ) and the group members tended to generally disclose information freely.

In addition, the Parent Training groups in this study indicated many positive features in view of the 21 subjects who completed the evaluation form (see Appendix G for a summary of the groups evaluation of the Parent Training sessions). Their comments reinforced specific ideas which related to the curative factors which were considered most helpful to Parent Training sessions in this study.

Findings of other parenting groups. One study by Anchor and Thomason (1977) which compared specific types of parent training models with educated parents provided a comparison for this study. This study found that parents were more trusting, friendly and optimistic after the group terminated. Certain curative factors that they found important were also important for this study sample. More specifically, 'Altruism', 'Group

'cohesiveness', 'Interpersonal learning "output"', and 'Instillation of hope'.

Findings of other relevant studies. The Q-sort questionnaire used in this study has been used and tested by other authors. Yalom (1975) provided the most comprehensive findings about the Q-sort which generally contrasted to the findings of this study. More specifically, Yalom, Tinklenberg and Gilula (1975) conducted long term group therapy with 21 psychiatric out-patients.

The focus of their therapy was insight oriented and directed toward understanding feelings and behavior through intensive group therapy. These authors found the following curative factors important. The curative factors ranked in descending order of importance were: 'Interpersonal learning "input"', 'Catharsis', 'Group cohesiveness', 'Self-understanding', 'Interpersonal learning "output"', 'Existential factors', 'Universality', 'Instillation of hope', 'Altruism', 'Family reenactment', 'Guidance', and 'Identification'. Two important variables influenced the rank order of these specific curative factors:

1) the nature of the group therapy, and 2) the length of time group members attended group therapy.

The curative factors ranked in descending order of importance for this study were: 'Instillation of hope', 'Altruism', 'Group cohesiveness', 'Catharsis', 'Universality', 'Guidance', 'Interpersonal learning "output"', 'Self-understanding', 'Identification', 'Family reenactment',

'Existential factors', and 'Interpersonal learning "input"'. Thus, the findings by Yalom, Tinklenberg and Gilula (1975) contrasted with the findings of this study. It suggests that the specific type of group therapy sets up the existence of specific curative factors.

Still, two curative factors were considered more important to both studies. This relates to the top six most helpful curative factors relative to the other factors. The two curative factors were 'Catharsis' and 'Group cohesiveness'. This finding is not surprising in view of the emotional atmosphere enhanced in intensive interactional group therapy as well as in parent discussion/training groups. So too, 'Group cohesiveness' is an essential component of all group therapies.



### Conclusions

The conclusions of this study are presented according to: 1) Background and Descriptive Findings 2) Q-sort analyses 3) Limitations and 4) Recommendations.

### Background and Descriptive Findings

The background and demographic data previously presented, described a predominately middle-lower class group of parents. Most of the parents were female. All had at least one child between the ages of 5-12 years.

The majority of the sample were female, middle-lower class SES parents who were likely to be unemployed and married. All of the men in the sample were of middle class SES and were married and employed. Half of the sample lived in St. John's most of their lives, whereas another 38% lived in a rural environment outside the city. Thus, it was apparent that the parents of this study lived in two distinct environments, rural versus urban.

The family characteristics of each group member indicated an average of 2.4 children per family with an equal distribution of female and male children. The age range of their children was 2-16 years. In view of these demographic findings, this was a group of parents, namely middle-lower class who had specific parenting concerns.

### The Q-sort Analyses

Analyses of the findings of the Q-sort questionnaire indicated that the three Parent Training Groups of the

study ranked specific curative factors as being more helpful than others. In examining the respective group data, the response patterns for the three PT groups were not discernibly different. Thus, the groups were treated as one data set for the ensuing analyses.

In considering the results, it should be noted that the responses on the Q-sort were ranked from least helpful to most helpful. Thus, least frequently endorsed items were not necessarily unimportant but were instead deemed as less important, relative to the others.

In view of the rank ordering of the 12 curative factors, six factors were deemed as more important than the others. A criterion of 4.00 on the 7-point scale was the cutting point indicating a level of being 'helpful' to the group members. The six most helpful curative factors for the study in descending order were: 1) 'Instillation of hope', 2) 'Altruism', 3) 'Group cohesiveness', 4) 'Catharsis', 5) 'Universality', and 6) 'Guidance'.

These curative factors were helpful to group members for several reasons noted in the discussion of this report. From the standpoint of clinical relevance, it seems worthwhile to summarize the positive strengths of the Parent Training Groups in view of the above cited curative factors.

First, the co-leaders were honest and open to the parents. The leaders acknowledged that they were not

parents and thus, encouraged parents to rely on each other for help. The co-leaders directly facilitated such curative factors as: 'Altruism', 'Catharsis', 'Universality', and 'Instillation of hope' in the various sessions.

Second, the informal and relaxed atmosphere of the group sessions was non-threatening to the parents. This atmosphere seemingly enhanced such curative factors as: 'Altruism', 'Instillation of hope', and 'Group cohesiveness'.

Thirdly, the technique of allowing for a review of past discussion topics and incorporating these ideas into the weekly session reinforced a common theme towards parenting. In this regard, the 'Guidance' curative factor was also directly facilitated by the co-leaders.

Fourth, the co-leaders asked one parent who attended a previous PT group to talk with new parents attending their initial PT session. This parent reinforced several ideas, e.g., 'Instillation of hope', and 'Universality'.

Fifth, a fixed time and place was arranged for the PT sessions. This instilled some feeling of security and enhanced group responsibility and 'Group cohesiveness'.

Sixth, the size of the PT groups was seemingly conducive to facilitate interactive group discussions. The group members enjoyed free expression, openness and trust. This also seemingly enhanced the 'Group cohesiveness' curative factor.

Seventh, the co-leaders continuously asked for feedback and encouraged constant input from group members. The co-

leaders also encouraged suggestions from group members and implemented some of these suggestions into the PT sessions. This approach enhanced such factors as 'Interpersonal learning "output"', and 'Group cohesiveness'.

Eighth, the PT groups provided a positive outlet for socialization for mothers, who were unemployed yet worked at home. These mothers began to relate to the other parents and felt more confident about their general coping skills as parents. They often needed more help and feedback from the group because they spent most of their time at home, therefore having limited contact with other parents. Thus, the PT groups enhanced such curative factors as 'Interpersonal learning "output"', 'Catharsis', 'Instillation of hope', and 'Universality' for these mothers.

Ninth, the co-leaders and guest speakers provided information on community services which parents could utilize where they identified specific life problems. The availability of community services provided hope for these parents and also enhanced the 'Guidance' curative factor.

Tenth, the attitude of the co-leaders was essentially non-judgemental toward the parents. For example, the parents were accepted as having basic rights similar to their children. An overall positive view on parent responsibility, with permission to make mistakes and learn from them was also emphasized. These attitudes inevitably enhanced 'Universality', 'Instillation of hope', 'Altruism', and 'Group cohesiveness'.

Overall, the Parent Training Groups set up the existence of specific curative factors as being most helpful. Parenting



was generally viewed as a positive learning experience with most group members accepting the fact, that they needed help as parents.

In this context, the findings may be interpreted in the following ways. First, the nature and purpose of the groups definitely enhanced some curative factors more so than others. In general, those that were deemed as less important were not stressed, and consequently were not deemed as being important. Second, as previously mentioned, the therapists themselves directly impacted on the same factors more so than others. Future research, therefore, should consider these two important influences on the curative factors when assessing their relative degree of importance for evaluation or outcome of group therapy.

### Limitations

More comparative studies regarding the nature of curative factors existing in Parent Training Groups would have enriched the findings of this study. For example, PT groups of diverse social classes of parents, different focused groups, different group sizes, or having different sex compositions may have presented a range of different curative factors as being most helpful. Although, there were numerous research studies pertaining to PT and parent education, there was no known study that evaluated PT groups by implementing Yalom's (1975) Q-sort questionnaire. Many studies evaluated the outcome of PT in regard to specific variables, e.g., behavior change of the child, cohesiveness of the group,

socioeconomic status and educational level of parents. Still, there was adequate research available on specific curative or outcome factors pertaining to PT. In regard to Yalom's Q-sort questionnaire, it seemingly tapped all of the possible outcome factors crucial in group therapy.

Yalom (1975) administered his Q-sort to one specific type of group therapy, namely, intensive interactional therapy with psychiatric out-patients. Still, the categories of curative factors did pertain to other group therapies, most notably PT.

The Q-sort was a standardized instrument used by other researchers (Yalom, 1975; Lieberman, Yalom and Gilula, 1975; Weiner, 1974). The forced choice component of the questionnaire set up certain limitations, as parents were forced to place a specific number of items in each pile. In addition, all of the ratings were helpful relative to each other, and ranked on a 7-point scale of helpfulness. Many parents found this task both confusing and difficult. Thus, the least frequently endorsed items were not necessarily unimportant but were deemed less important relative to the others.

In addition, certain curative factors were not pertinent to the group because of the number of group sessions and the duration of therapy. In essence, the degree of importance of specific curative factors was relevant only to the specific type of group therapy that was administered to the parents. If the PT groups were scheduled for longer periods of time, perhaps certain curative factors may have been rated as being more important than others. For example, 'Interpersonal

learning "input", 'Identification', and 'Self-understanding' are factors which have been shown to evolve in long term group therapy.

The sample was small ( $n=21$ ) which also limited the extent to which the findings could be readily generalized. In addition, the sample was not unique to the general population of Newfoundland. The subjects were all self-selected which may have influenced the curative factor ratings. All the parents indicated an interest in attending the PT group by responding to an advertisement in a local newspaper. These sample limitations reduce the capability for making inferences from the study data.

One would be remiss not noting the bias or influence of the co-therapists upon the curative factors. For example, the co-therapists planned the PT sessions along specific clinical lines in view of the type of parents who attended PT. The co-leaders instilled 'Hope', 'Guidance', and 'Group cohesiveness' by their very presence in the group. Despite this, the study indicated the existence of specific curative factors which may be construed as outcomes to the group therapy experience.

Finally, one must view the compliance of the group members who answered the open-ended questions set up by the therapists, as well as completed the instruments of study. For example, the group members were quite willing to complete the Q-sort questionnaire as well as the evaluation form. Few parents were resistant or felt uncomfortable in taking part in the research study. The most frequently

noted complaint was that specific items on the Q-sort were irrelevant and not pertinent to the group. Still, a positive view prevailed as parents all felt that they were 'normal' parents with 'normal' children, and had 'normal' problems.

### Recommendations

Specific recommendations from the method and findings of the study are listed as follows:

- 1) In future research of this nature, PT groups should be carefully organized so that selection of the members' needs are consistent with a specific age group of children, e.g., pre-schoolers, adolescents, etc... Parents who participate who have a diverse age range of children reveal too many age discrepancies and problems, which are difficult to successfully manage in this type of group therapy.
- 2) PT sessions which focus on parents of pre-school aged children require therapy which focuses on educational and preventive aspects of parenting. The parents of pre-school aged children can apply these same principles at later stages of their children's development. For example, learning effective communication techniques may be applied to any parent-child relationship.
- 3) Parents who attended the past PT groups should be introduced as guest speakers into a new PT group. These guest speakers may in turn, help orient new group members to the group sessions. Such curative factors as 'Instillation of hope', and 'Guidance' would come into effect as



well as these parents providing instant credibility to the PT groups.

4) The PT groups could be organized at any service agency where there is access to parents. For example, schools, church, nursery pre-school services, etc.,.

5) Guest speakers who speak at PT sessions should focus on relevant issues of concern for group members. For example, a teacher could be asked to be a guest speaker where parents issue problems with teachers or school systems.

6) All PT groups should make some therapy sessions available for parents who have individual interests. Certain parents may request a special session, e.g., shoplifting, sex, bedwetting, communicating with your adolescent, etc.,. Thus, parents may feel more motivated to attend, particularly if their individual interests are given priority.

7) All guest speakers should be oriented to the educational/informational needs of the group members. Their topics should be selected and consistent with the goals of the therapy.

8) The PT groups should provide time to hear out individual concerns at strategic points during the PT sessions. For example, therapists could set aside 15 minute sessions for each parent during the duration of the group. Each parent would have time to ask the co-leaders specific questions outside the group sessions. Some parents may require individual therapy at which time this could be discussed. The importance of confidentiality and respecting parents' individual rights is also essential and consequently an important part of the group therapy sessions.

9) In certain situations, PT groups could be organized into different time formats, as follows:

- a) A PT group could be scheduled for a short time with a closed group of parents. For example, a PT group scheduled for seven weeks with 2-hour weekly sessions could be considered short-term group therapy.
- b) A PT group could be scheduled for long-term therapy with a closed group of parents. For example, a PT group scheduled for 20 weeks with 2-hour weekly sessions.
- c) A PT group could be scheduled for a one day workshop. For example, a 'Marathon' group situation.

10) PT groups could be organized into different formats in view of the agenda topics. For example, group therapy could focus on one specific topic or on several topics of interest to parents, e.g., Assertiveness Training, Communication Skills Training. However, all PT groups should cater to the needs of the parents.

11) PT groups with a focus on long-term group therapy could extend particular sessions to the whole family. For example, husband-wife teams could meet for one weekly session focused on how to communicate effectively with your adolescent or, the whole family could partake in a weekend 'Marathon' session with other families to focus on a particular problem, e.g., sexuality and open communication in the family.

12) Relaxation training could be introduced in some PT sessions and used to help parents learn to relax. Another way of introducing relaxation training is to organize it as a

special discussion topic for an initial PT session. For example, parents often feel anxious and unsure of themselves in the initial sessions of group therapy, thus many may welcome relaxation training.

13) Compulsory attendance at all sessions of group therapy should also be stressed. This helps maintain consistency and group cohesiveness. Thus, the parents should be encouraged to take responsibility for their participation and consider the needs of the group that they are committed to attend.

14) Co-leaders need to set clear criteria for selection of group members prior to the beginning of the group sessions. Ample time must be taken in the pre-selection process to ensure that the criteria is met.

15) PT groups need co-leaders who have some experience in conducting PT sessions. By having clinical experience, co-leaders may provide instillation of hope, trust, guidance, and credibility to the group members.

16) Co-therapists who are not parents should attempt to involve guest speakers who are parents, if at all possible. This could enhance such curative factors as 'Instillation of hope', 'Guidance', and 'Identification'.

17) The physical setting of PT groups should be conducive to promoting free and open discussion. This setting should include such things as: access to refreshments, proper lighting, informal atmosphere, comfortable seating arrangements, few interruptions and an accessible location for participants.

18) It is essential that therapists attempt to evaluate the

effectiveness of PT group therapy. Some form of a standardized instrument should be used and administered to group members to achieve this purpose.

19) The use of index cards gave parents an opportunity to write out their problems or concerns, when it was difficult to disclose them in the group. Co-leaders should encourage the use of these cards and pass out index cards with written examples of parenting concerns to be used for discussion purposes.

20) Avenues should be available for follow-up services for particular group members who require additional individual therapy. For example, bringing in a guest speaker from a specific community service or agency and who would be receptive to seeing parents with specific parenting problems. In addition, co-therapists could make group members aware of possible community services they could utilize for their specific problems.

This study examined the effectiveness of one specific type of group therapy, namely Parent Training. The major focus of PT was educational with open discussion and feedback encouraged. All group members who attended PT sessions disclosed common problems, yet generally viewed parenting in a positive light. PT was considered as helpful to the parents who participated in this study. In fact, specific curative or outcome factors were viewed as helpful to the group process. All parents were instilled with hope that they would overcome their problems or at least find some



means of coping. Finally, further research in this field is recommended.

APPENDICES

## Appendix A

The terms group therapy and parent training are used somewhat interchangeably in this thesis. This is not to imply that they mean the same thing, but more so as indicated in the concept definitions (see page 5 of this study), group therapy is a broad and general concept of which parent training is a part.

Subjects who participated in the Parent Training group sessions were informed that the group would be termed as Parent Training. Still, the group members were informed by the co-leaders that Parent Training incorporated therapy, education, and training components. It was felt that all group members understood that Parent Training was a form of group therapy.



## Appendix B



Curative Factors

1. Altruism
  1. Helping others has given me more self-respect.
  2. "Putting others' needs ahead of mine.
  3. Forgetting myself and thinking of helping others.
  4. Giving part of myself to others.
  5. Helping others and being important in their lives.
2. Group cohesiveness
  6. Belonging to and being accepted by a group.
  7. Continued close contact with other people.
  8. Revealing embarrassing things about myself and still being accepted by the group.
  9. Feeling alone no longer.
  10. Belonging to a group of people who understood and accepted me.
3. Universality
  11. Learning I'm not the only one with my type of problem; "We're all in the same boat".
  12. Seeing that I was just as well off as others.
  13. Learning that others have some of the same "bad" thoughts and feelings I do.
  14. Learning that others had parents and had backgrounds as unhappy or mixed up as mine.
  15. Learning that I'm not very different from other people gave me a "welcome to the human race" feeling.
4. Interpersonal learning "input"
  16. The group's teaching me about the type of impression I make on others.
  17. Learning how I come across to others.
  18. Other members honestly telling me what they think of me.
  19. Group members pointing out some of my habits or mannerisms that annoy other people.
  20. Learning that I sometimes confuse people by not saying what I really think.
5. Interpersonal learning "output"
  21. Improving my skills in getting along with people.
  22. Feeling more trustful of groups and of other people.
  23. Learning about the way I related to the other group members.

5. Interpersonal learning "output" (Cont'd)
  24. The group's giving me an opportunity to learn to approach others.
  25. Working out my difficulties with one particular member in the group.
  26. The doctor's suggesting or advising something for me to do.
  27. Group members suggesting or advising something for me to do.
6. Guidance
  28. Group members telling me what to do.
  29. Someone in the group giving definite suggestions about a life problem.
  30. Group members advising me to go behave differently with an important person in my life.
  31. Getting things off my chest.
  32. Expressing negative and or positive feelings toward another member.
7. Catharsis
  33. Expressing negative and/or positive feelings toward the group leader.
  34. Learning how to express my feelings.
  35. Being able to say what was bothering me instead of holding it in.
  36. Trying to be like someone in the group who was better adjusted than I.
8. Identification
  37. Seeing that others could reveal embarrassing things and take other risks and benefit from it helped me to do the same.
  38. Adopting mannerisms or the style of another group member.
  39. Admiring and behaving like my therapist.
  40. Finding someone in the group I could pattern myself after.
  41. Being in the group was, in a sense, like reliving and understanding my life in the family in which I grew up.
9. Family reenactment
  42. Being in the group somehow helped me to understand old hang-ups that I had in the past with my parents, brothers, sisters, or other important people.
  43. Being in the group was, in a sense, like being in a family, only this time a more accepting and understanding family.
  44. Being in the group somehow helped me to understand how I grew up in my family.

9. Family  
reenactment  
(Cont'd)

45. The group was something like my family - some members or the therapist being like my parents and others being like my relatives. Through the group experience, I understand my past relationships with my parents and relatives (brothers, sisters, etc.).

10. Self-  
understanding

46. Learning that I have likes or dislikes for a person for reasons which may have little to do with the person and more to do with my hang-ups or experiences with other people in my past.

47. Learning why I think and feel the way I do (i.e., learning some of the causes and sources of my problems).

48. Discovering and accepting previously unknown or unacceptable parts of myself.

49. Learning that I react to some people or situations unrealistically (with feelings that somehow belong to earlier periods in my life).

50. Learning that how I feel and behave today is related to my childhood and development (there are reasons in my early life why I am as I am).

11. Instillation  
of hope

51. Seeing others getting better was inspiring to me.

52. Knowing others had solved problems similar to mine.

53. Seeing that others had solved problems similar to mine.

54. Seeing that other group members improved, encouraged me.

55. Knowing that the group had helped others with problems like mine encouraged me.

12. Existential  
factors

56. Recognizing that life is at times unfair and unjust.

57. Recognizing that ultimately there is no escape from some of life's pain and from death.

12. Existential  
factors  
(Cont'd)

- 58. Recognizing that no matter how close I get to other people, I must still face life alone.
- 59. Facing the basic issues of my life and death, and thus living my life more honestly and being less caught up in trivialities.
- 60. Learning that I must take ultimate responsibility for the way I live my life no matter how much guidance and support I get from others.

You have 60 cards with a specific item written on each card. Please place a specific number of cards into each pile, labelled in the following manner:

Pile

1. Most helpful to me in the group (2 cards)
2. Extremely helpful " (6 cards)
3. Very helpful " (12 cards)
4. Helpful " (20 cards)
5. Barely helpful " (12 cards)
6. Less helpful " (6 cards)
7. Least helpful to me in the group (2 cards)



Initials: \_\_\_\_\_

Date: \_\_\_\_\_

Group: \_\_\_\_\_

1 parent attending \_\_\_\_\_  
Couple attending \_\_\_\_\_DIRECTIONS

- \*\* To protect your privacy, please DO NOT write your name on this questionnaire.
- \*\* Please try to answer all questions on your own. Just give ONE answer for each question.
- \*\* If you have any questions, feel free to ask by raising your hand.
- \*\* Your answers will not be seen by anyone and will be held in STRICTEST CONFIDENCE.

PART 1

Please answer by CIRCLING the number or WRITING in the correct response for each question.

## GENERAL BACKGROUND:

Sex: 1= Male 2= Female

Age: In actual years \_\_\_\_\_

Marital Status: 1= Single, never married

2= Married

3= Widowed

4= Divorced

5= Separated

6= Common-law relationship

If previously married, how many times? \_\_\_\_\_

Race: 1= Black, 2= White, 3= Other

Where have you lived most of your life?

1= In a large city (250,000 or more)

2= In a small city or town (i.e., less than 250,000)  
St. John's

3= In the suburbs (Mt. Pearl, Kilbride, Torbay)

4= In a rural environment ("Around the Bay")

#### OCCUPATIONAL BACKGROUND

Are you currently employed? 1= Yes 2= No

What is the highest occupational level you have ever achieved?

1= Higher executive, proprietor of a large concern, major professional

2= Business manager of a large concern, proprietor of a medium-sized business

3= Administrative personnel, owner of a small independent business, minor professional

4= Clerical or sales worker, technician, owner of a little business

5= Skilled manual employee

6= Machine operator, semi-skilled employee

7= Unskilled employee

8= Never worked in paid employment

What is the longest period of time you have ever held a steady job?

Years \_\_\_\_\_ Months \_\_\_\_\_ Weeks \_\_\_\_\_

#### EDUCATIONAL BACKGROUND

What is the highest level of education you have completed?

1= Graduate or professional training

2= College graduate

3= Some college or technical school

4= High school graduate

5= Some high school

6= Junior high school

7= Less than 7 years of school

FAMILY:

Number, ages and sex of children in the family

<u>Males</u>	<u>Ages</u>	<u>Females</u>	<u>Ages</u>
<u>0</u>		<u>0</u>	
<u>1st</u>	<u>      </u>	<u>1st</u>	<u>      </u>
<u>2nd</u>	<u>      </u>	<u>2nd</u>	<u>      </u>
<u>3rd</u>	<u>      </u>	<u>3rd</u>	<u>      </u>
<u>4th</u>	<u>      </u>	<u>4th</u>	<u>      </u>
<u>5th</u>	<u>      </u>	<u>5th</u>	<u>      </u>
<u>6th</u>	<u>      </u>	<u>6th</u>	<u>      </u>
<u>7th</u>	<u>      </u>	<u>7th</u>	<u>      </u>

Did you attend parent training sessions before?

## Appendix C



PLANNED PARENTHOOD ASSOCIATION OF  
NEWFOUNDLAND AND LABRADOR

WILL BE SPONSORING

PARENT TRAINING SESSIONS

for parents of children  
ages 5-12 years old.

DATE: September 30-November 11, 1981  
(Wednesday evening)

TIME: 8:00-10:00 p.m.

LOCATION: Planned Parenthood office, 21 Factory Lane,  
St. John's, Newfoundland

FORMAT: Mini-lectures by guest speakers on topics  
such as discipline, school problems,  
communication skills. Opportunity for  
discussion among parents; with group co-  
leaders; and guest speakers.

REGISTRATION: Limited. Call 753-7333 (daytime) or  
579-4427, 364-1630 (evenings).

FEE: \$10.00 per parent.



PLANNED PARENTHOOD ASSOCIATION OF  
NEWFOUNDLAND AND LABRADOR

WILL BE SPONSORING

PARENT TRAINING SESSIONS

for parents of children

ages 5-12 years old.

DATE: May 20-July 1, 1981 (Wednesday evening)  
May 21-July 2, 1981 (Thursday evening)

TIME: 8:00-10:00 p.m.

LOCATION: Planned Parenthood office, 21 Factory Lane,  
St. John's, Newfoundland

FORMAT: Mini-lectures by guest speakers on topics  
such as discipline, school problems,  
communication skills. Opportunity for  
discussion among parents; with group co-  
leaders; and guest speakers.

REGISTRATION: Limited. Call 753-7333 (daytime) or  
579-4427, 364-1630 (evenings).

FEE: \$10.00 per parent.

## Appendix D

# CONTENT OF PARENT TRAINING SESSIONS

## Session 1 8:00-10:00 p.m.

- Registration of group members.
- Introduction of group co-leaders.
- Introduction of group members.
- Distribution of pre-test questionnaire.
- Distribution of the background and descriptive data sheet.
- Description of group: purpose, time of sessions, location, etc.
- Outline of tentative agenda for the seven PT sessions.
- Parent discussion regarding outline of sessions.
- Ice breaker exercise for group members as a means of members talking about their specific concerns as parents. One problem or interest area was to be identified by each group member.
- End of session.

## Session 2 8:00-10:00 p.m.

### 8:00-8:30 p.m. Education Session

Presented by guest speaker, Melba Rabinowitz, Director of Daybreak Parent-Child Centre.

TOPIC: How to build your child's self-esteem.

8:30-9:00 p.m. Questions and open discussion.

9:00-9:10 p.m. Coffee Break

9:10-9:30 p.m. \*Mini lecture by co-leaders.

TOPIC: 'Behavior is a Statement of Feeling'.

\*All mini lectures by the co-leaders relate to lecture material presented by D. P. Ripley (1977).

Session 2 8:00-10:00 p.m. (Cont'd)

9:30-9:45 p.m. Group exercise: Examples on cue cards on how to build your child's self-esteem. Group members were broken down into two small groups. Small group discussion on the mini lecture material as well as incorporating the parents' ideas on self-esteem relating to the parent-child relationship.

9:45-10:00 p.m. Concluding remarks.  
End of session.

Session 3 8:00-10:00 p.m.

8:00-8:30 p.m. Education Session

Presented by guest speaker, Dr. Strawbridge, Psychologist, Memorial University, Psychology Department.

TOPIC: The Effects of Television Violence on Children.

8:30-9:00 p.m. Questions and open discussion.

9:00-9:10 p.m. Coffee break

9:10-9:30 p.m. \*Mini lecture by co-leaders.

TOPIC: 'Building a better relationship with your child through Sensitive Expression'.

9:30-9:45 p.m. Group exercise: Examples on cue cards of Sensitive Expression. Group members were broken down into two small groups. Small

\* All mini lectures by the co-leaders relate to lecture material presented by D. P. Ripley (1977).

Session 3 8:00-10:00 p.m. (Cont'd)

group discussion on the mini lecture material, as well as parents feelings of the effects of television violence on their children.

9:45-10:00 p.m. Concluding remarks.

End of session.

Session 4 8:00-10:00 p.m.

8:00-8:30 p.m. Education Session

Presented by guest speaker, Barbara Hopkins, Co-ordinator, Diagnostic and Remedial Unit, Memorial University.

TOPIC: School problems, parent-child, parent-teacher communication.

8:30-9:00 p.m. Questions and open discussion.

9:00-9:10 p.m. Coffee Break

9:10-9:30 p.m. \*Mini lecture by co-leaders.

TOPIC: 'How to build a better relationship with your child through Sensitive Listening'.

9:30-9:45 p.m. Group exercise: Examples on cue cards of Parent-Child school problems. Group members were broken down into two small groups. Small group discussion on how to incorporate Sensitive Listening to dealing with your child's school problems.

9:45-10:00 p.m. Concluding remarks.

End of session.

\* All mini lectures by the co-leaders relate to lecture material presented by D. P. Ripley (1977).



Session 5 8:00-10:00 p.m. (Cont'd)8:00-8:30 p.m. Education Session

Presented by guest speaker, Dr. Marcia Smith, Pediatrican, Communication-Development Clinic, Janeway Hospital.

TOPIC: Discipline and your Child.

8:30-9:00 p.m. Questions and open discussion.

9:00-9:10 p.m. Coffee Break

9:10-9:30 p.m. \*Mini-lecture by co-leaders.

TOPIC: 'Problem Solving Model--Part 1'.

9:30-9:45 p.m. Group exercise: Examples on cue cards of Problem Solving Model. Group members were broken down into two small groups. Small group discussion on how to problem solve in relation to specific discipline problems with your child.

9:45-10:00 p.m. Concluding remarks.

End of session.

Session 6 8:00-10:00 p.m.8:00-8:30 p.m. Education Session

Presented by guest speaker, Gary Green, Assistant Professor, Counselling Centre, Memorial University.

TOPIC: Relaxation Training for Parents.

8:30-9:00 p.m. Questions and open discussion.

9:00-9:10 p.m. Coffee Break

\* All mini lectures by the co-leaders relate to lecture material presented by D. P. Ripley (1977).

Session 6 8:00-10:00 p.m. (Cont'd)

9:10-9:30 p.m. \*Mini lecture by co-leaders.

TOPIC: 'Problem Solving Model--Part 11'.

9:30-9:45 p.m. Group exercise: Examples on cue cards on how to problem solve effectively. Group members were broken down into two small groups. Small group discussion on the mini lecture material, as well as the parents' feelings on relaxation training.

9:45-10:00 p.m. Concluding remarks.

End of session.

Session 7 8:00-10:00 p.m.

-Summary of group.

-Evaluation form completed by group members.

-Post test questionnaire distributed to all group members.

-Q-sort questionnaire distributed to all group members.

-All research questionnaires completed by group members.

10:00 p.m. Closing Social.

\* All mini lectures by the co-leaders relate to lecture material presented by D. P. Ripley (1977).

## Appendix E

Group Evaluation

Initials: \_\_\_\_\_

Date: \_\_\_\_\_

Directions:

Please complete the following sentences.

(1) I found taking part in the parent training group to be \_\_\_\_\_  
\_\_\_\_\_(2) I found the opportunity for discussion in the group to be \_\_\_\_\_  
\_\_\_\_\_(3) I found the mini-lectures presented by the group leaders themselves to be: \_\_\_\_\_  
\_\_\_\_\_

(4) I found the topics presented by the guest speakers to be:

TopicsComments

Self-esteem \_\_\_\_\_

School problems \_\_\_\_\_

Television violence \_\_\_\_\_

Discipline \_\_\_\_\_

Relaxation \_\_\_\_\_

(5) I found the makeup of the group (size, time, place, length of sessions) to be: \_\_\_\_\_  
\_\_\_\_\_(6) The most useful feature of the group was \_\_\_\_\_  
\_\_\_\_\_(7) The least useful feature of the group was \_\_\_\_\_  
\_\_\_\_\_



(8) The group helped me to learn something about \_\_\_\_\_

(9) I would be interested in attending another group for  
parents at a later time:

Yes \_\_\_\_\_

No \_\_\_\_\_

(10) Other comments: \_\_\_\_\_

Thank you for sharing your opinions.

B. Vincent and D. Lawlor

Note (See Appendix H for permission by B. Vincent  
for Group Evaluation form to be copied)



## Appendix F

# RANK ORDER OF 60 ITEMS IN ORDER OF IMPORTANCE

<u>Curative Factors</u>	<u>60 Items</u>	<u>Rank Order</u> (T denotes Tie)
1. Altruism	1. Helping others has given me more self-respect	17T
	2. Putting others' needs ahead of mine.	9T
	3. Forgetting myself and thinking of helping others.	17T
	4. Giving part of myself to others.	9T
	5. Helping others and being important in their lives.	17T
	6. Belonging to and being accepted by a group.	17T
2. Group cohesiveness	7. Continued close contact with other people.	22T
	8. Revealing embarrassing things about myself and still being accepted by the group.	9T
	9. Feeling alone no longer.	12T
	10. Belonging to a group of people who understood and accepted me.	7T
3. Universality	11. Learning I'm not the only one with my type of problem; "We're all in the same boat".	1
	12. Seeing that I was just as well off as others.	12T
	13. Learning that others have some of the same "bad" thoughts and feelings I do.	21
	14. Learning that others had parents and had backgrounds as unhappy or mixed up as mine.	51
	15. Learning that I'm not very different from other people gave me a "welcome to the human race" feeling.	30
	16. The group's teaching me about the type of impression I make on others.	55
4. Interpersonal learning "input"	17. Learning how I come across to others.	27T
	18. Other members honestly telling me what they think of me.	54
	19. Group members pointing out some of my habits or mannerisms that annoy other people.	60

Rank Order

- |                                       |  |     |
|---------------------------------------|--|-----|
| 4. Interpersonal learning<br>"input"  | 20. Learning that I sometimes confuse people by not saying what I really think.          | 33T |
| 5. Interpersonal learning<br>"output" | 21. Improving my skills in getting along with people.                                    | 29  |
|                                       | 22. Feeling more trustful of groups and of other people.                                 | 24  |
|                                       | 23. Learning about the way I related to the other group members.                         | 36T |
|                                       | 24. The group's giving me an opportunity to learn to approach others.                    | 33T |
|                                       | 25. Working out my difficulties with one particular member in the group.                 | 52T |
| 6. Guidance                           | 26. The doctor's suggesting or advising something for me to do.                          | 52T |
|                                       | 27. Group members suggesting or advising something for me to do.                         | 15T |
|                                       | 28. Group members telling me what to do.   | 42  |
|                                       | 29. Someone in the group giving definite suggestions about a life problem.               | 4T  |
|                                       | 30. Group members advising me to behave differently with an important person in my life. | 25T |
|                                       | 31. Getting things off my chest.   | 4T  |
| 7. Catharsis                          | 32. Expressing negative and or positive feelings toward another member.                  | 31T |
|                                       | 33. Expressing negative and/or positive feelings toward the group leader.                | 43T |
|                                       | 34. Learning how to express my feelings.   | 12T |
|                                       | 35. Being able to say what was bothering me instead of holding it in.                    | 7T  |
|                                       |  |     |



Rank Order

## 8. Identification

- 36. Trying to be like some one in the group who was better adjusted than I. 35
- 37. Seeing that others could reveal embarrassing things and take other risks and benefit from it helped me to do the same. 22T
- 38. Adopting mannerisms or the style of another group member. 56T
- 39. Admiring and behaving like my therapist. 48T
- 40. Finding someone in the group I could pattern myself after. 48T
- 41. Being in the group was, in a sense, like reliving and understanding my life in the family in which I grew up. 39T

## 9. Family reenactment

- 42. Being in the group somehow helped me to understand old hang-ups that I had in the past with my parents, brothers, sisters, or other important people. 48T
- 43. Being in the group was, in a sense, like being in a family, only this time a more accepting and understanding family. 31T
- 44. Being in the group somehow helped me to understand how I grew up in my family. 46T
- 45. The group was something like my family - some members or the therapist being like my parents and others being like my relatives. Through the group experience, I understand my past relationships with my parents and relatives (brothers, sisters, etc.). 56T

Rank Order

- |                          |  |     |
|--------------------------|--|-----|
|                          | 46. Learning that I have likes or dislikes for a person for reasons which may have little to do with the person and more to do with my hang-ups or experiences with other people in my past. | 56T |
| 10. Self-understanding   | 47. Learning why I think and feel the way I do (i.e., learning some of the causes and sources of my problems).   | 15T |
|                          | 48. Discovering and accepting previously unknown or unacceptable parts of myself.  | 39T |
|                          | 49. Learning that I react to some people or situations unrealistically (with feelings that somehow belong to earlier periods in my life).  | 38  |
|                          | 50. Learning that how I feel and behave today is related to my childhood and development (there are reasons in my early life why I am as I am).  | 46T |
|                          | 51. Seeing others getting better was inspiring to me.  | 27T |
|                          | 52. Knowing others had solved problems similar to mine.  | 6   |
| 11. Instillation of hope | 53. Seeing that others had solved problems similar to mine.  | 3   |
|                          | 54. Seeing that other group members improved encouraged me.  | 25T |
|                          | 55. Knowing that the group had helped others with problems like mine encouraged me.  | 2   |



Rank Order12. Existential  
factors

56. Recognizing that life is at times unfair and unjust. 43T
57. Recognizing that ultimately there is no escape from some of life's pain and from death. 59
58. Recognizing that no matter how close I get to other people, I must still face life alone. 39T
59. Facing the basic issues of my life and death, and thus living my life more honestly and being less caught up in trivialities. 43T
60. Learning that I must take ultimate responsibility for the way I live my life no matter how much guidance and support I get from others. 36T

## Appendix G

### Discussion of Group Members' evaluation of Parent Training Sessions

Parent Training groups in this study indicated many positive features in view of the 21 subjects who responded to an evaluation form (see Appendix D).

Several useful features of the Parent Training groups were confirmed by many of the parents. The following responses were frequently cited: "Being able to discuss openly my problems"; "The size of the group helped encourage open discussion"; "Talking out problems and picking up suggestions from others in the group"; "Being able to talk freely to other parents"; "Getting things off my chest"; "Meeting other parents who were similar to me"; "Learning what to expect when my children get older"; and "Learning to cope better as a parent".

The least helpful features of PT were also noted. Three points were emphasized as follows: "Age variation of children was too diverse"; "Certain child-parent problems relating to a specific age group were not helpful"; and "Presentation of specific guest speaker was not relevant and was boring". These three ideas were quickly picked up by the co-leaders. The presentation of a specific guest speaker focused on two points: 1) the style of the guest speaker, and 2) the topic presented. The wide variation in ages of children indicated that certain parenting concerns were not relevant to all the parents. For example, a parent who focused on her teen's problem or her pre-schooler was

different from concerns of parents focusing on their children between the ages of 5-12 years.

Overall, the general comments by the parents were favourable. Parents viewed Parent Training as a group therapy which helped them cope with their concerns. The sharing of feelings and problems with other parents gave the group members help in solving or coping with their problems. All in all, group members viewed themselves as 'normal' parents with 'normal' children. The supportive milieu of group therapy provided hope.

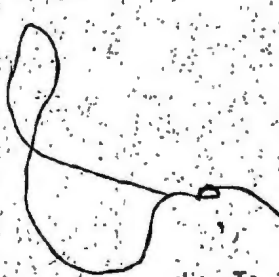


## Appendix H




Permission letter for copyrighted material

April 26, 1982



I, Beverley Vincent give permission for my  
colleague and co-leader, Denise Lawlor to print  
and copy our Group Evaluation form in her study.



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